Supreme Court, U.S.
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No.

IN THE

Supreme Court of the United States

HEWLETT-PACKARD COMPANY EMPLOYEE BENEFITS ORGANIZATION INCOME PROTECTION PLAN,

Petitioner,

v.

DONALD JEBIAN,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

PETITION FOR A WRIT OF CERTIORARI

SUPREME COURT, U.S.
POLICE DEPARTMENT

FEB 20 2004

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QUESTION PRESENTED

This Court held in *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101 (1989), that the denial of ERISA benefits by a plan administrator with discretionary authority is reviewed for abuse of discretion. Does the standard of review change where the benefits claim is "deemed" denied by the passage of time? The courts of appeals have answered this question in three conflicting ways.

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

The caption contains the names of all of the parties to the proceeding in the court below. Pursuant to Rule 29.6 of the Rules of this Court, petitioner Hewlett-Packard Company Employee Benefits Organization Income Protection Plan states that it is not a corporation. Instead, petitioner is an employee benefit plan recognized as a separate legal entity under Section 502(d)(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. § 1132(d)(1). Therefore, Rule 29.6 does not appear to apply. In the interest of full disclosure, petitioner further states that its sponsoring employer, Hewlett-Packard Company, which is not a party to this litigation, is a corporate entity that has issued shares to the public and has the following affiliates that have also issued shares to the public: HLCL (publicly traded in India) and MTI Technology (publicly traded in Taiwan).

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PETITION FOR A WRIT OF CERTIORARI

Petitioner Hewlett-Packard Company Employee Benefits Organization Income Protection Plan (the "Plan") respectfully submits this petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit.

OPINIONS BELOW

The initial opinion of the court of appeals (App., *infra*, 47a-72a), which has been withdrawn, is reported at 310 F.3d 1173. The subsequent opinion of the court of appeals (App., *infra*, 1a-30a), as amended on rehearing, is reported at 349 F.3d 1098. The order of the district court granting the Plan's motion for summary judgment (App., *infra*, 31a-41a) is not reported.

JURISDICTION

The district court had federal question jurisdiction over this ERISA action pursuant to 28 U.S.C. § 1331. The court of appeals had jurisdiction pursuant to 28 U.S.C. § 1291. The court of appeals originally entered judgment on November 19, 2002, and the Plan filed a timely petition for rehearing. On November 25, 2003, the court of appeals again entered judgment. That same day, the court also denied the Plan's petition for rehearing. App., *infra*, 42a-43a. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

Pursuant to this Court's Rule 14.1(f), ERISA §§ 502(a) and 503, 29 U.S.C. §§ 1132(a) and 1133; and 29 C.F.R. § 2560.503-1 (1998 and 2003) are set forth in the Appendix, *infra*, 73a-107a.

STATEMENT OF THE CASE

After the Plan's claims administrator exercised its discretionary authority to deny respondent Jebian's claim for disability benefits, Jebian's appeal was "deemed" denied by the passage of time; Jebian sued the Plan under ERISA, and the appeal was subsequently rejected on the merits. The district court, applying an abuse of discretion standard of review, granted summary judgment to the Plan on the ground that the denial of benefits was "entirely reasonable." In a 2-1 decision, the court of appeals reversed, holding that the claims administrator's benefits determination should be reviewed *de novo* solely because of the "deemed" denial of Jebian's internal appeal.

1. Hewlett-Packard Company ("HP") adopted the Plan to provide its employees with income in the event of certain specified disabilities and sponsored the Plan through the Hewlett-Packard Company Employee Benefits Organization (the "Organization"), which is the named fiduciary and plan administrator under ERISA. App., *infra*, 113a, 142a-143a. The Plan is entirely self-funded by HP. *Id.* at 124a.

Under the Plan, Voluntary Plan Administrators, Inc. ("VPA") serves as the Plan's independent claims administrator pursuant to an Administrative Services Agreement. App., *infra*, 164a-229a. VPA has no incentive to deny claims. Benefits are not paid from VPA's assets. Instead, VPA is compensated based upon a flat quarterly fee, not on the number of claims processed, the dollar amount paid out, or the number of claims approved or denied. *Id.* at 173a-177a.

2. Disability plans are a form of employee welfare benefit plan governed by ERISA. ERISA § 3(1), 29 U.S.C. § 1002(1). ERISA requires that "every employee benefit plan shall . . . afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." ERISA § 503(2), 29 U.S.C.

§ 1133(2). The implementing regulation required, *inter alia*, that the participant be given written notice of the decision on review "not . . . later than 60 days after the plan's receipt of a request for review." 29 C.F.R. § 2560.503-1(h)(1)(i) (1998). If the plan administrator determines that additional time is required, it must so notify the participant within the original 60 days, and in no event shall a decision be rendered "later than 120 days after receipt of a request for review." *Ibid.*; 29 C.F.R. § 2560.503-1(h)(2) (1998) The Plan at issue in this case tracked these regulatory requirements. *See* App., *infra*, 140a-142a, 169a-170a.[1]

Under the terms of the Plan, "[i]f a claimant has not received written notice that additional time is required for review within sixty (60) days of the date his or her request for review is [received] by the Claims Administrator, the claim shall be deemed to have been denied on review." App., *infra*, 142a; *see also* 29 C.F.R. § 2560.503-1(h)(4) (1998) (appeals neither timely decided nor extended are deemed denied).[2] As this Court has explained, such a provision "enables a claimant to bring an action to have the merits of the application determined, just as he may bring an action to challenge an outright denial of benefits." *Mass. Mut. Life Ins. Co.* v. *Russell*, 473 U.S. 134, 144 (1985).

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[1] The regulation has been amended to shorten the time to respond to a claim to 45 days and to require that appeals be considered by an individual other than the one that initially denied the claim or a subordinate of that individual. The amendments are effective only as to claims filed after January 1, 2002. *See* 29 C.F.R. § 2560.503-1(f)(3), -1(h)(3)(ii), -1(h)(4), -1(o) (2003).

[2] The amended regulation does not refer to deemed denials, but provides that where a decision is not made within the time limits, "a claimant shall be deemed to have exhausted the administrative remedies available under the plan," thus allowing for immediate judicial review. 29 C.F.R. § 2560.503-1(*l*) (2003).

Although ERISA and its implementing regulations set forth a comprehensive regime governing benefits determinations, they do not establish a standard of review if a participant brings suit to challenge the denial of benefits. This Court filled that gap in *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101 (1989), holding that "a denial of benefits challenged under [29 U.S.C.] § 1132(a)(1)(B) is to be reviewed under a *de novo* standard *unless* the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." 489 U.S. at 115 (emphasis added). If the plan does confer such discretion, benefits determinations made by the administrator or fiduciary are reviewed only for an abuse of discretion. *Id.* at 111-12.

Here, the Plan expressly confers discretionary authority on both the named fiduciary and the plan administrator to interpret the Plan documents and to make benefit determinations. *See* App., *infra*, 139a. Specifically, the Plan provides that "[t]he Organization is the named fiduciary which has the discretionary authority to act with respect to any appeal from a denial of benefits. The Organization's discretionary authority includes the authority to determine eligibility for benefits and to construe the terms of the Plan." *Ibid.*

The discretionary authority to make benefits determinations, including deciding appeals from benefits denials, has been delegated to the claims administrator, VPA. App., *infra*, 139a; *see* ERISA § 405(c), 29 U.S.C. § 1105(c) (authorizing delegation of fiduciary responsibilities). VPA is authorized to "process[] claims," including making determinations of "Total Disability" on the "basis of objective medical evidence." App., *infra*, 161a-162a. In so doing, VPA "shall have the discretionary power to construe the language of the Plan." *Id.* at 141a. The Plan further states that VPA "shall administer the review of denied claims on the Organization's behalf and make the decision on review." *Id.* at 139a.

3. Respondent began his employment with HP in 1983 and worked as a software engineer until June 2, 1997, when he applied for a short-term disability leave. App., *infra*, 2a-4a. On February 6, 1998, he filed a claim with VPA for long-term disability ("LTD") benefits under the Plan in which he described his disability as "severe congenital and acquired lumbar stenosis," or a bad back. *Id.* at 2a-4a, 33a; C.A. App. 113. Under the Plan, respondent would qualify for LTD benefits if he satisfied the definition of "Total Disability" on March 3, 1998. App., *infra*, 18a.

A Plan participant applying for LTD benefits, such as respondent, must show that, after the thirty-ninth week of receiving short-term disability benefits, he or she "is continuously unable to perform *any occupation* for which he or she is or may become qualified by reason of his or her education, training or experience." App., *infra*, 118a (emphasis added). Respondent thus bore the burden of establishing that he was completely unable to work.

To evaluate respondent's ability to perform work-related tasks, VPA hired HealthSouth, a company that assesses the functional capacities of individuals with disability claims to conduct a Work Capacities Assessment of respondent. App., *infra*, 4a. HealthSouth reported that respondent's gait was normal and that he was able to lift in the medium category of work. C.A. App. 96-102, 223. HealthSouth reported that respondent had a "moderate" to "minimal" decrease in his range of motion. *Ibid.* HealthSouth also indicated that respondent demonstrated a tolerance of sitting, walking, trunk bending, overhead reaching, squatting, crouching, kneeling, keying, fine motor skills, and a host of other physical activities on a frequent basis. App., *infra*, 4a, 33a-34a; C.A. App. 96-102, 222-23.

VPA also hired Rehab West, an independent vocational specialist, to provide an Employability Assessment Report determining what occupations, if any, respondent was or

could become qualified to perform in light of his "educational, vocational, and physical capabilities." C.A. App. 114. Rehab West reported to VPA that based on the medical reports VPA had provided, respondent could perform four different occupations: User Support Analyst; Data Processing Auditor; Sales Representative, Computers and EDP Systems; and Technical Training Instructor. App., *infra*, 4a-5a.

Based on the HealthSouth and Rehab West reports, VPA concluded that respondent did "not meet the definition of disability as required by the Plan." C.A. App. 121; App., *infra*, 4a, 34a. VPA communicated this determination to respondent by notice dated August 3, 1998. The notice also described the procedures for appealing VPA's decision. *Id.* at 34a.

On August 18, 1998, respondent wrote to VPA stating his intention to appeal the denial of his claim for LTD benefits. On November 11, 1998, respondent submitted a letter to VPA in which he formally appealed the denial of LTD benefits and outlined the bases for his appeal. App., *infra*, 34a-35a. One of the grounds for appeal was that VPA had failed to consider certain medical records, including an assessment of respondent made by a Dr. Chang. C.A. App. 103-04. On March 15, 1999—more than 60 days but less than 120 days after VPA received the appeal—VPA responded to certain aspects of respondent's appeal, and offered to consider further information from respondent's physicians before rendering a final decision on the appeal. App., *infra*, 35a. In particular, VPA requested additional medical documentation from Dr. Chang and other physicians. C.A. Supp. App. 69. On June 11, 1999, VPA wrote to respondent to inform him that several of his doctors, including Dr. Chang, had not yet provided further information to VPA, and expressed a willingness to keep respondent's file open until it received that information. App., *infra*, 35a; C.A. App. 92. After respondent filed suit rather than providing the requested informa-

tion, VPA notified him on November 5, 1999 that his appeal had been denied, and provided a detailed explanation of the reasons for that denial. App., *infra*, 36a. As VPA explained, "[b]ecause the medical documentation on file does not support Total Disability as defined [in the Plan], we have no alternative other than to uphold our original decision to deny [respondent's] claim for LTD benefits." C.A. Supp. App. 63.

4. Jebian sued the Plan under ERISA § 502(a)(1)(B), which authorizes "a civil action . . . by a participant . . . to recover benefits due to him under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B). He sought all benefits due under the Plan. C.A. App. 1-3.

a. The district court granted summary judgment to the Plan. App., *infra*, 31a-41a. The court concluded that the Plan vests VPA with discretion to decide benefits claims and held that the appropriate standard of review was whether VPA had abused its discretion in denying respondent's claim. *Id.* at 33a, 37a. The court rejected respondent's argument that because his appeal was decided beyond the time limits provided by the Plan and the ERISA regulation, *de novo* review was warranted. *Id.* at 37a n.2. The court specifically noted that respondent had been on notice of VPA's need for further information, that it was respondent's obligation to provide the necessary information to support his appeal, and that respondent "cannot now claim that VPA failed to engage in a meaningful dialogue with [him] regarding his appeal and shirk his responsibility under the Plan." *Ibid.* Expressly finding "that there was a meaningful exchange of information between VPA and plaintiff," C.A. App. 232, the court ruled that VPA had not acted "arbitrarily, capriciously, or unreasonably" in denying respondent's claim for LTD benefits. App., *infra*, 41a.

b. In its first opinion, the court of appeals reversed because, among other things, in its view the district court had failed to apply the so-called "treating physician rule" dictated

by then-recent circuit precedent. App., *infra*, 52a, 59a-63a; *see Regula* v. *Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130 (9th Cir. 2001), *vacated*, 123 S. Ct. 2267 (2003). While the Plan's petition for rehearing was pending, this Court issued its decision in *Black & Decker Disability Plan* v. *Nord*, 123 S. Ct. 1965 (2003), unanimously rejecting the Ninth Circuit's application of the treating physician rule in ERISA cases.

In light of *Nord*, the court of appeals withdrew its earlier opinion and issued a new opinion, authored by Judge Berzon and joined by Judge Pregerson, once again reversing the district court's grant of summary judgment. App., *infra*, 1a-30a. The court acknowledged that the Plan confers discretion upon VPA to decide claims and that VPA's benefits determination would therefore be entitled to judicial deference under *Firestone*. The court concluded, however, that no deference is due where an administrator does not decide the appeal within the time period provided for by the Plan (and the then-applicable regulation). *Id.* at 6a-15a. According to the Ninth Circuit, "[d]eemed denials are not exercises of discretion. They are therefore undeserving of deference under *Firestone*, and a *de novo* standard of review applies." *Id.* at 11a-12a.

The court then opined that, under a *de novo* standard, there was sufficient evidence to give rise to a triable issue of fact regarding whether respondent was totally disabled on March 3, 1998, thus precluding summary judgment in favor of the Plan. App., *infra*, 17a-18a. Moreover, the majority invited the district court to reach beyond the four corners of the administrative record: "While under an abuse of discretion standard our review is limited to the record before the plan administrator, this limitation does not apply to *de novo* review." *Id.* at 19a (citation omitted).[3]

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[3] The Ninth Circuit also opined that although this Court has nullified the treating physician rule in ERISA cases, the district court must never-

Judge Tashima dissented. App., *infra*, 21a-30a. In his view, "the record reveals that the independent plan administrator . . . did exercise its discretion in denying [respondent]'s appeal." *Id.* at 21a. He concluded that "[t]o apply the non-deferential, de novo standard of review solely because of a procedural irregularity is an extreme measure warranted neither by the facts of this case nor by the cases on which the majority relies." *Ibid.* Judge Tashima noted that "the majority's conclusion conflicts with all but one of the decisions that have dealt with the precise issue we face." *Ibid.* The dissent also took strong issue with "the majority's characterization of the facts" regarding whether there was "substantial compliance" with the relevant time limits, listing in detail the evidence demonstrating the "meaningful dialogue" between the parties. *Id.* at 28a-29a. Judge Tashima observed that "[b]esides being bad law, the majority's position is also bad policy," because "where the delay is caused by the claimant's failure to furnish the plan administrator with the needed medical records, the majority's decision will force plan administrators to deny such claims within the permitted period, rather than to risk awaiting receipt of the required medical records." *Id.* at 29a.

REASONS FOR GRANTING THE WRIT

As this Court has recognized, a "deferential standard for reviewing benefit denials" is "highly prized by benefit plans." *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355, 384 (2002). That is because *de novo* judicial review is much more burdensome on plans (and the district courts) than review for abuse of discretion. Under the latter approach, the court must determine only whether the administrator's decision was reasonable, regardless of whether the court would

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theless give the opinions of treating physicians "weight." App., *infra*, 18a n.8.

have come to the same conclusion independently. *Restatement (Third) of Trusts* § 50 cmt. b (2003) ("A court will not interfere with a trustee's exercise of a discretionary power when that exercise is reasonable and not based on an improper interpretation of the terms of the trust. Thus, judicial intervention is not warranted merely because the court would have differently exercised the discretion."). Under a *de novo* approach, by contrast, the district court must scrutinize the administrative record (and, under the Ninth Circuit's view, even materials that were not presented by the claimant to the administrator) and make an independent determination on the claim for benefits. In light of the increased costs and complexities of such a proceeding, the standard of review has rightly been called "[o]ne of the critical issues in benefit claim litigation." Steven J. Sacher et al., *Employee Benefits Law* 984 (2d ed. 2000).

The circuits are deeply divided, however, on the standard of review applicable to "deemed denials" of benefit claims that occur because of the passage of time limits established by plan or regulation: The Fifth and Sixth Circuits apply an abuse of discretion standard to such decisions, the Third and Ninth Circuits review such decisions *de novo*, and the Eighth and Tenth Circuits apply an intermediate approach. This conflict is significant because the Department of Labor has estimated that 14 *million* decisions annually are not made within prescribed time limits. *See* Pension and Welfare Benefits Administration, 65 Fed. Reg. 70,246, 70,257 (Nov. 21, 2000). One of ERISA's goals was to "establish a uniform administrative scheme," *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 9 (1987), but such "[u]niformity is impossible . . . if plans are subject to different legal obligations in different states." *Egelhoff* v. *Egelhoff*, 532 U.S. 141, 148 (2001). Judicial review of deemed denials by plan administrators should not vary based only on the geographic location of the claimant.

I. The Federal Courts Of Appeals Are Deeply Divided Regarding The Proper Standard Of Review Where ERISA Benefits Claims Are "Deemed" Denied

The federal courts of appeals have decided numerous cases presenting the precise question at issue here: the standard of review district courts are to use in evaluating denials of ERISA benefits claims where the claims are "deemed" denied at any stage of the plan's claims process as the result of passage of time. As the court below acknowledged, the circuits have taken sharply divergent approaches to this issue. *See* App., *infra*, 12a ("conclusions in similar cases vary"); *id.* at 21a (Tashima, J., dissenting) (decision below "creates an inter-circuit conflict").[4]

A. The Abuse Of Discretion Approach

In *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101 (1989), this Court held that benefits denials are reviewed for an abuse of discretion where the plan vests discretion in the plan administrator to make such determinations. Two circuits have held that this abuse-of-discretion standard is equally applicable to "deemed" denials.

In *Southern Farm Bureau Life Insurance Co.* v. *Moore*, 993 F.2d 98 (5th Cir. 1993), the Fifth Circuit reversed a jury verdict obtained by a claimant seeking accidental death benefits where the plan administrator failed to respond to the claimant and thus the claim was "deemed" denied pursuant to

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[4] In *Torres* v. *Pittston Co.*, 346 F.3d 1324 (11th Cir. 2003), the Eleventh Circuit, which has not yet weighed in on this issue, noted the conflict among the circuits. "Some courts have held that . . . a deemed denial receives no deference upon judicial review, since the plan administrator did not in fact exercise any discretion." *Id.* at 1332-33. "Others, however," the court continued, "have held that the fact that the denial occurs by operation of ERISA regulations does not alter the otherwise-applicable standard of review." *Id.* at 1333. And as explained below, two courts hold that a deemed denial *may* affect the standard of review.

the claims-processing regulation. 993 F.2d at 99-101. The court noted this Court's decision in *Massachusetts Mutual Life Insurance Co.* v. *Russell*, 473 U.S. 134 (1985), which concluded that the purpose of a "deemed" denial provision is to "enable[] a claimant to bring an action to have the merits of his application determined, just as he may bring an action to challenge an outright denial of benefits." 993 F.2d at 101 (quoting *Russell*, 473 U.S. at 144). "In our view," the Fifth Circuit concluded, "the standard of review is no different whether the claim is actually denied or is deemed denied." *Ibid.* Reviewing the administrator's factual determinations for an abuse of discretion, the court held that the plan was entitled to judgment as a matter of law. *Id.* at 102-04.

In *Daniel* v. *Eaton Corp.*, 839 F.2d 263 (6th Cir. 1988), a former employee sued to recover retirement benefits, and the plan administrator denied his claim and then failed to respond to his appeal, resulting in a deemed denial. *Id.* at 264-65, 267. In an analysis very similar to the Fifth Circuit's subsequent decision in *Moore*, the Sixth Circuit rejected the former employee's argument that a deemed denial should result in *de novo* review. *Id.* at 267. "[T]he standard of review is no different whether the appeal is actually denied or is deemed denied." *Ibid.*[5]

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[5] In a subsequent case, another panel of the Sixth Circuit stated in dictum in a footnote that there is "undeniable logic in the view that a plan administrator should forfeit deferential review by failing to exercise its discretion in a timely manner." *Univ. Hosps. of Cleveland* v. *Emerson Elec. Co.*, 202 F.3d 839, 846 n.3 (6th Cir. 2000). The Ninth Circuit in the decision below cited this dictum to suggest that the Sixth Circuit has "left open the standard of review question." App, *infra*, 14a. The Ninth Circuit is plainly wrong in this regard. *Daniel* is binding circuit precedent, subsequent dictum notwithstanding. The Sixth Circuit will apply an abuse of discretion standard unless and until the en banc Sixth Circuit or this Court adopts a different rule. *See* 6th Cir. R. 206(c).

B. The *De Novo* Approach

In sharp contrast to the approach of the Fifth and Sixth Circuits, two circuits have held that "deemed" denials should be reviewed *de novo* even where the plan confers discretionary authority to make benefits determinations.

In *Gritzer* v. *CBS, Inc.*, 275 F.3d 291 (3d Cir. 2002), former employees applied for pension benefits, but their claims were deemed denied as a result of the plan administrator's failure to respond to their claims within the applicable time period. *Id.* at 294. The district court reviewed the plan's denials of benefits under a heightened arbitrary and capricious standard and granted the plan's motion for summary judgment. *Id.* at 294-95. On appeal, the former employees challenged, *inter alia*, the standard of review.

The Third Circuit noted that although the plan gave the administrator "essentially unfettered discretion to interpret the Plan and to determine entitlement to its various benefits," the administrator "apparently never made any effort to analyze appellants' claims much less to advise them of what that analysis disclosed until after this litigation was filed." 275 F.3d at 295. The court concluded that "[i]n these circumstances, there simply is no analysis or 'reasoning' to which the Court may defer under the arbitrary and capricious standard." *Id.* at 296 (citation omitted). The Third Circuit noted that this Court's decision in *Firestone*, which requires that ERISA benefit determinations be reviewed for an abuse of discretion where the plan confers discretion, "was predicated on basic trust law principles." 275 F.3d at 296. Continuing with the analogy to trust law, the court opined that "[w]here a trustee fails to act or to exercise his or her discretion, de novo review is appropriate because the trustee has forfeited the privilege to apply his or her discretion," because "it is the trustee's analysis, not his or her right to use discretion or a mere arbitrary denial, to which a court should defer." *Ibid.*

Applying *de novo* review, the Third Circuit rejected the former employees' claims for benefits. *Id.* at 296-99.

In the decision below, the Ninth Circuit similarly employed a *de novo* standard, as noted above. *See supra* pp. 8-9; App., *infra*, 6a, 12a. In the Ninth Circuit's view, "[d]eemed denials are not exercises of discretion" and "a *de novo* standard of review applies." *Id.* at 11a-12a.

C. The Substantial Compliance Approach

Two circuits have adopted an intermediate approach, under which a "deemed" denial may be reviewed for abuse of discretion or *de novo* depending on the circumstances of the particular case.

In *McGarrah* v. *Hartford Life Insurance Co.*, 234 F.3d 1026 (8th Cir. 2000), an ERISA plan administrator terminated an employee's disability benefits and did not respond to his internal appeal of that decision, and the employee sought judicial review. *Id.* at 1027, 1029. The district court applied an abuse of discretion standard and granted the plan's motion for summary judgment. *Id.* at 1027-28. On appeal, the employee challenged, *inter alia*, the standard of review.

The Eighth Circuit began its analysis of the standard of review issue by noting that under *Firestone* "the abuse-of-discretion standard applies if, as in this case, the plan expressly gives the administrator discretion to determine eligibility for benefits and to construe the terms of the plan." 234 F.3d at 1030. The court then turned to the administrator's "failure to respond" to the employee's appeal, which it labeled "a serious procedural irregularity" in violation of both the plan language and the claims-processing regulation. 234 F.3d at 1031. The court observed that "the mere presence of a procedural irregularity is not enough to strip a plan administrator of the deferential standard of review." *Ibid.* The court stated that a claimant must also show that a procedural irregularity "raises 'serious doubts as to whether the result

reached was the product of an arbitrary decision or the plan administrator's whim.'" *Ibid.* (quoting *Buttram* v. *Cent. States Southeast & Southwest Areas Health & Welfare Fund*, 76 F.3d 896, 900 (8th Cir. 1996)).[6] The Eighth Circuit concluded that the employee "failed to meet this rigorous standard" because the record confirmed that the administrator had considered the relevant facts and was adequate "to permit meaningful judicial review." *Ibid.* Applying the abuse of discretion standard, the court affirmed the judgment. *Id.* at 1031-32.

In *Gilbertson* v. *Allied Signal, Inc.*, 328 F.3d 625 (10th Cir. 2003), the Tenth Circuit considered a claim denial in which the plan administrator and the claimant initially engaged in communications that could reasonably constitute an extension of the 120-day decision window, but the administrator subsequently ceased communicating with the claimant and never issued a decision on the appeal. *Id.* at 627-29, 636. The Tenth Circuit held that in such circumstances, *de novo* review was appropriate. *Id.* at 630-37. In doing so, however, the court set forth a standard that would require the opposite result here and in many other cases.

The Tenth Circuit began its analysis by noting that courts have "been willing to overlook administrators' failure to meet certain procedural requirements when the administrator has substantially complied with the regulations and the process as a whole fulfills the broader purposes of ERISA and its accompanying regulations." 328 F.3d at 634. "We agree that a 'substantial compliance' approach is appropriate

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[6] Circumstances that could raise such doubts include "where the plan trustee does not inquire into the relevant circumstances at issue; where the trustee never offers a written decision, so that the applicant and the court cannot properly review the basis for the decision," or where the "procedural irregularities are so egregious that the court has a total lack of faith in the integrity of the decision making process." 234 F.3d at 1031 (quoting *Buttram*, 76 F.3d at 900).

in this case. Accordingly, our holding does not require that every decision that comes on the 61st or 121st day following the claimant's notice of appeal must be subject to plenary review in federal court." *Id.* at 634-35.

The *Gilbertson* court concluded that "in the context of an ongoing, good faith exchange of information between the administrator and the claimant, inconsequential violations of the deadlines or other procedural irregularities would not entitle the claimant to *de novo* review." 328 F.3d at 634-35. The court observed that the fundamental purpose behind the procedural requirements concerning denials of ERISA benefits is to foster a "meaningful dialogue." *Ibid.* (citation omitted). "[A]n administrator who fails to render a timely decision" will nevertheless "be in substantial compliance with ERISA's procedural requirements if there is an ongoing productive evidence-gathering process in which the claimant is kept reasonably well-informed as to the status of the claim and the kinds of information that will satisfy the administrator." *Id.* at 636. Because the plan administrator had simply stopped communicating with the claimant altogether, including failing to respond to repeated letters from the claimant's attorney requesting a decision, the court held that after a certain point—possibly after the "deemed denied" date—there was no longer a "meaningful dialogue," and thus the *de novo* standard applied. *Id.* at 636-37.[7]

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[7] The Ninth Circuit, in the decision below, stated that it found "the reasoning in *Gilbertson* . . . most illuminating" and purported to adopt the Tenth Circuit's flexible approach to handling "inconsequential violations of the deadlines." App., *infra*, 14a-15a. The majority below, however, then proceeded to apply a standard far different from anything contemplated by *Gilbertson*, indeed simply ignoring the district court's findings regarding the Plan's substantial compliance and meaningful dialogue with respondent. *See, e.g.*, C.A. App. 232; App., *infra*, 14a-15a. The majority's mishandling of the facts relevant to the *Gilbertson* analysis prompted strong criticism from Judge Tashima in dissent. *Id.* at 29a-30a. Indeed, a subsequent unpublished Ninth Circuit case construing the ruling

The *Gilbertson* court expressly recognized the existing circuit conflict: "Other circuits . . . have decided the issue differently." 328 F.3d at 633. Thus, it is beyond dispute that the circuits are genuinely and deeply split regarding the question presented, as the courts themselves—including the court below—have acknowledged.

II. The Decision Below Is Erroneous

This Court's decision in *Firestone* holds that where an ERISA plan confers discretion upon an administrator to make benefits determinations, courts should not upset an administrator's decision "except to prevent an abuse . . . of his discretion." 489 U.S. at 111 (quotation omitted). "Trust principles make a deferential standard of review appropriate when a trustee exercises discretionary powers." *Ibid.* Such discretion exists where "the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.* at 115.

The discussion of the standard of review in *Firestone* relied on Section 187 of the *Restatement (Second) of Trusts*, the precursor to Section 50 of the *Restatement (Third) of Trusts*. *See* 489 U.S. at 111. The current *Restatement* formulation confirms that "[a] discretionary power conferred upon the trustee to determine the benefits of a trust beneficiary is subject to judicial control only to prevent misinterpretation or abuse of the discretion by the trustee." *Restatement (Third) of Trusts* § 50(1) (2003); *see also id.* cmt. b ("A court will not interfere with a trustee's exercise of a discretionary power when that exercise is reasonable and not based on an improper interpretation of the terms of the trust"). The Plan

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below confirms that in practice the Ninth Circuit will treat virtually any procedural misstep by a plan as requiring *de novo* review. *See Walker* v. *Long-Term Disability Plan of Sponsor Tri-Valley Growers*, No. 02-15728, 2003 WL 22954288 (9th Cir. Dec. 10, 2003).

in this case conferred discretionary authority on VPA to make benefits determinations, and thus under *Firestone* and the *Restatement* its decisions are reviewable only for abuse of that discretion. The Ninth Circuit's contrary conclusion is wrong.

1. The court of appeals said that "[d]eference to an exercise of discretion requires discretion actually to have been exercised." App., *infra*, 11a. But officials frequently make important decisions through discretionary inaction. For example, if the President does not return a bill to Congress within ten days, it becomes law (if the legislature is in session) or is subject to a "pocket veto" (if the legislature has adjourned). *See* U.S. Const. art. 1, § 7. The decision to allow the constitutional period to expire can hardly be labeled "non-discretionary." Rather, such decisions (to the extent they are reviewable at all) remain subject to the abuse of discretion standard. *Restatement (Third) of Trusts* § 50 cmt. b (2003).

The Third Circuit, in a similar vein, has said that a trustee's failure to act constitutes a "forfeit[ure of] the privilege to apply his or her discretion." *Gritzer*, 275 F.3d at 296. But a decision by a trustee not to act is not necessarily an abuse of discretion. Instead, the question is whether a trustee has "*improperly*" failed to act. *Restatement (Third) of Trusts* § 50 cmt. b (2003) (emphasis added). "[E]ven where a trustee has discretion whether or not to make any payments to a particular beneficiary, the court will interpose if the trustee, *arbitrarily* or *without knowledge of or inquiry into relevant circumstances*, fails to exercise the discretion." *Ibid.* (emphases added).

Thus, neither *Firestone* nor common-law trust principles warrant applying different standards of review to deemed denials and actual denials. Of course, the circumstances under which an ERISA plan administrator chooses not to issue a final decision regarding a claim or in the course of an internal

appeal may inform a court's analysis of whether the administrator abused its discretion. It might, for example, be possible in some cases for a participant to prove that the administrator's failure to resolve the internal appeal within the time limits set forth in a plan is evidence of, or itself constitutes, an abuse of discretion, either because the inaction was arbitrary or because the administrator did not inquire into the relevant circumstances before deciding not to act. *Cf.* Brief of Amicus Curiae United States at 15-17, *Black & Decker Disability Plan* v. *Nord*, 123 S. Ct. 1965 (2003) (No. 02-469) (explaining that an administrator's arbitrary failure to address the opinions of a treating physician could, in a particular case, constitute an abuse of discretion). But it would be the participant's burden to make that showing, which has not been made—and could not be made—on the facts of this case.

Here, Jebian received a detailed written description of the reasons why his claim was denied. Within 120 days of his appeal from that determination, VPA informed him why his initial submission was insufficient to warrant a reversal, and explained what additional information would be required to sustain his burden of proof. VPA subsequently informed him that some doctors had not provided that additional information, but offered to leave the file open to provide him a further opportunity to supply the information. When Jebian sued instead, VPA sent a full explanation of its decision based on the record that he had chosen to submit. *See supra* pp. 6-7. Were, as here, the record demonstrates the basis for the administrator's ruling, as will ordinarily be the case even where a claim may be "deemed" denied by the passage of time, the courts will have no difficulty discerning whether the administrator exercised its discretion and, if so, whether that discretion was abused.

2. Under *Firestone*, therefore, where a plan confers discretion upon an administrator to make a decision, that deci-

sion should be subject to deferential judicial review under which a claimant must demonstrate convincingly that the administrator's discretion has been abused. By contrast, the rule followed by the Ninth Circuit, as well as the Third Circuit, treats plan and regulatory provisions concerning "deemed" denials of claims as effecting a complete (and automatic) withdrawal of discretion from the plan administrator. That approach fundamentally misunderstands the purpose and nature of a deemed denial.

The "deemed denial" provisions of the Plan and the former regulation simply define the earliest time that a participant may bring an action to enforce his or her rights under ERISA. The courts of appeals have unanimously concluded that a plan participant *must* exhaust his or her remedies under the plan, including the internal review process required by ERISA § 503, 29 U.S.C. § 1133, before bringing a civil action for benefits under ERISA § 502(a), 29 U.S.C. § 1132(a). *See, e.g.*, *Fallick* v. *Nationwide Mut. Ins. Co.*, 162 F.3d 410, 418 & n.4 (6th Cir. 1998) (citing cases). This exhaustion requirement creates the possibility of administrative limbo: A plan administrator could effectively preclude a participant from obtaining judicial review by delaying action on the internal appeal. The "deemed denial" provision of the Plan (and the then-applicable regulation) rectified this problem by allowing participants to proceed to court after passage of a time certain, regardless of the administrator's inactivity.

This Court has already considered deemed denials and concluded that they "enable[] a claimant to bring a civil action to have the merits of his application determined, just as he may bring a civil action to challenge an outright denial of benefits." *Russell*, 473 U.S. at 144. The regulation now in effect clarifies that where a plan fails to adhere to regulatory time frames, "a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section

502(a)." 29 C.F.R. § 2560.503-1(*l*) (2003). Thus, the time limitation is not—and never was intended to be—a withdrawal of the administrator's discretion to make benefits determinations, but rather governs the procedural question of when a beneficiary can stop participating in the administrative process and proceed to federal court.

Indeed, it is quite telling that the language the Plan and the regulation use is that the claim is "deemed"—*i.e.*, *regarded as*—denied, but not *actually* denied, where sufficient time has elapsed. A deemed denial of an internal appeal, therefore, merely defines the right of a claimant to pursue judicial review at a specific time without awaiting further exhaustion of plan remedies. It does *not* render an otherwise discretionary decision by the plan administrator subject to plenary review. Rather, the claimant retains the burden of proving that the administrator abused its discretion under the standards set forth in *Firestone* and the *Restatement*.[8]

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[8] With regard to the current version of the regulation, the Department of Labor has expressed the view that "the procedural minimums of the regulation are essential to procedural fairness and that a decision made in the absence of the mandated procedural protections should not be entitled to any judicial deference." 65 Fed. Reg. at 70,255. That statement is best understood as applicable to plans, such as the one at issue in *Firestone*, that had not established procedures to comply with ERISA § 503, 29 U.S.C. § 1133, and its implementing regulation. *See* 489 U.S. at 105. The Plan here, by contrast, has established such procedures, and benefit determinations made pursuant to those procedures (including deemed denials) are entitled to deference under *Firestone*. Indeed, the Labor Department has recognized that "claimants bear the burden of proving to the satisfaction of the court that the plan failed to establish or follow claims procedures consistent with the requirements of the regulation" and "a plan will be accorded significant deference in evaluating whether it failed to follow a procedure consistent with those aspects of the regulation." *Frequently Asked Questions about the Benefit Claims Procedure Regulation* ("FAQs"), www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html, Question F-2 (as visited Feb. 18, 2004); *see Black & Decker Disability Plan* v. *Nord*, 123 S. Ct. 1965, 1972 (2003) (deferring to views expressed in these

III. The Issue Is Important, Substantial, And Recurring

The amendments to the ERISA regulation do not resolve the issue of what standard of review applies in the context of a deemed denial.[9] Whether and under what circumstances the passage of time limits imposed by plan or regulation might affect the degree of judicial deference to the administrator's decision plainly will continue to have significant ramifications for how plans process their claims. Under most plans, the claimant retains the burden of establishing the incorrectness of an initial denial. Those claimants who are unable to adduce sufficient information to substantiate the appeal within the time imposed by the regulation risk having their claims denied, because the decision below creates a strong incentive for plans to deny claims based upon material already in the record where the participant has failed to pro-

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FAQs). Moreover, the Department has explained that "not every deviation by a plan from the requirements of the regulation justifies proceeding directly to court." FAQs, Question F-2. That is because, according to the Department, if the deviation can be corrected by the plan "through the internal appeal process or otherwise, then there ordinarily will not have been a failure to establish or follow reasonable procedures as contemplated by § 2560.503-1(*l*)." *Ibid.* It follows *a fortiori* that where such a deviation is not material (or, in the *Restatement* formulation, unreasonable), or where it has been corrected by the plan, the deference that normally attaches to discretionary benefits determinations under *Firestone* is not forfeited. The Department of Labor's guidance thus indicates that the *per se* rule articulated by the Third Circuit, and endorsed by the Ninth, is incorrect. *See* United States Amicus Br. in *Nord*, at 11 ("The regulations thus reflect the Department's considered view that an *informal and flexible* system of claims processing best 'reconcile[s] the need for procedural protections with the purely voluntary nature of the system through which these vital benefits are delivered") (quoting 65 Fed. Reg. at 70,246) (emphasis added).

[9] The new regulation affects the *identity* of the person or entity with the discretionary authority to resolve internal appeals, but does not speak to the standard of review applicable if such appeals are deemed denied as a result of the passage of time limits set by regulation or plan documents.

vide the necessary additional information in a timely fashion. Keeping the record open past the time period in those circumstances would only add the cost and burdens of a *de novo* court proceeding to the plan's operations, to the disadvantage of other participants.

This issue potentially affects many millions of Americans in an area that is vital to their economic well-being, as underscored by the Department of Labor's recent estimate that 14 million claims per year are not decided within the regulatory time limits. *See* 65 Fed. Reg. at 70,257. The current uncertainty in the law poses an especially severe problem for large regional and nationwide ERISA plans that operate in multiple circuits applying inconsistent rules regarding the treatment of deemed denials. Either plan administrators will be forced to tailor their claim procedures to the most stringent standard that would limit the time in which claimants could submit new information sufficient to support their appeals, or the claims of similarly situated participants would be processed differently by jurisdiction. Neither result comports with the policies of ERISA. *See* FAQs, Question B-4 ("[T]he department intended to preserve the greatest flexibility possible for designing and operating claims processing systems consistent with the prudent administration of a plan. The department believes that prudent plan administration requires ensuring that similarly situated claims are, under similar circumstances, decided in a consistent manner.").

"Nothing in the legislative history [of ERISA] suggests that Congress intended that federal district courts would function as substitute plan administrators." *Taft* v. *Equitable Life Assurance Soc'y*, 9 F.3d 1469, 1472 (9th Cir. 1994) (quotation omitted). Nevertheless, that is exactly the direction in which the Third and Ninth Circuits, and to a lesser extent the Eighth and Tenth Circuits, have begun to shift ERISA jurisprudence, with the lower court here going one step further and inviting the district court on remand to go beyond the factual record presented to the administrator and to

evaluate respondent's disability claim with complete disregard for the Plan's administrative claim and review process. The approach adopted by the Fifth and Sixth Circuits, by contrast, preserves the role of the claims administrator as the primary fact-finder and decisionmaker where a plan confers discretionary authority upon the administrator, and thus avoids burdening the courts with potentially millions of cases per year presenting arcane matters of medical evidence and plan language.

As Judge Tashima noted below, and as the Tenth Circuit stated in *Gilbertson*, a rule subjecting plan determinations to *de novo* review in the event of a deemed denial would necessarily result in an unwarranted increase in the denial of benefits claims. The perverse effects of such a rule cannot be overemphasized. As the "deemed denied" date approaches, plan administrators will be affirmatively forced to deny claimants the opportunity to submit additional evidence in support of their claims, even though all parties might agree that further investigation and documentation was warranted and might result in an award of benefits. If a plan administrator's options are either to deny a claim on day 119 with the knowledge that its discretionary decision will be relatively immune to judicial review in light of the abuse of discretion standard and the state of the record before it, or to keep the claim open until day 121 to receive further evidence but subject to unrestricted judicial second-guessing under a *de novo* standard—with a potentially reopened and unconstrained factual record—the result is not only preordained but clearly one that neither Congress, nor employees or employees alike, ever contemplated or desired. The purpose of deemed denial provisions in plans and regulations is emphatically not to foreclose cooperative, good-faith efforts by claimants and benefits plans to investigate the merits of claims.

Nor is this issue likely to resolve itself any time soon. The circuits have taken patently divergent approaches to the

question presented, and no single position has emerged as predominant or likely to persuade other circuits to change their rules. As the law now stands, plan participants receive different levels of judicial review of benefits determinations depending only on geography: abuse of discretion in the Fifth and Sixth Circuits, *de novo* in the Third and Ninth, and "it depends" in the Eighth and Tenth. This Court's guidance is needed to resolve the three-way circuit split on this important issue of federal law.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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APPENDIX

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APPENDIX A

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

DONALD JEBIAN, *Plaintiff-Appellant,* v. HEWLETT-PACKARD COMPANY EMPLOYEE BENEFITS ORGANIZATION INCOME PROTECTION PLAN; ERISA PLAN, *Defendants-Appellees.*	No. 00-56988 D.C. No. CV-99-09548-RSWL OPINION

Appeal from the United States District Court
for the Central District of California
Ronald S.W. Lew, District Judge, Presiding

Argued and Submitted
December 3, 2001—Pasadena, California
Filed—November 19, 2002
Opinion Withdrawn November 25, 2003

Opinion Filed November 25, 2003

Before: Harry Pregerson, A. Wallace Tashima and Marsha S. Berzon, Circuit Judges.

Opinion by Judge Berzon;
Dissent by Judge Tashima

COUNSEL

Charles J. Fleishman, Beverly Hills, California, for the appellant.

Joseph P. Busch, III, Gibson, Dunn & Crutcher, Los Angeles, California, for the appellee.

OPINION

BERZON, Circuit Judge:

On November 19, 2002, we issued an opinion reversing the district court and remanding for further consideration. *Jebian v. Hewlett-Packard Co.*, 310 F.3d 1173 (2002). We stayed our mandate pending the Supreme Court's ruling in *Black & Decker Disability Plan v. Nord*, 123 S.Ct. 1965, 1969 (2003). We now issue a substituted opinion, reaffirming our earlier treatment of the appropriate standard of review in ERISA cases where benefits are "deemed denied" through the passage of time but withdrawing our instruction that the district court consider appellant's claims in the light of a "treating physician rule."

BACKGROUND

Donald Jebian, now sixty-three, worked as a software engineer for Hewlett Packard continuously from 1983 to May 1995. In 1990 he began to suffer from a series of orthopedic impairments that caused him pain and made it difficult for him to move normally.

Jebian first developed bilateral shoulder pain. It turned out that he had a massive rotator cuff defect in his right shoulder, which was not diagnosed until 1995. In 1992, Jebian also began to experience back pain. Doctors determined that the cause was lumbar spinal stenosis.[1] His doctors agree that his stenosis is congenital rather than the result of injury.

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[1] Spinal stenosis is a narrowing of the lumbar or cervical spinal canal that causes compression of nerve roots and resulting back pain.

Later, Jebian was diagnosed with lumbar degenerative disc disease, which exacerbated his back pain.

Jebian stopped work in May 1994 because of intractable back pain. He had a lumbar discectomy in June 1995, the first of several surgeries. Because his back pain persisted after the surgery, he had a second surgery on his back in the fall of 1995. Dr. Stark, who examined Jebian at Hewlett Packard's request with regard to a worker's compensation claim in October 1995, predicted that Jebian would need yet another surgery on his back. Jebian also underwent two surgeries on his shoulders in 1996, one on each.

Jebian was a participant in an employee benefit plan ("the Plan") covered by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et. seq*. The Plan, self-funded by Hewlett Packard and administered by an independent claims administrator, Voluntary Plan Administrator ("VPA"), offers both short-term and long-term disability leave. Short-term disability benefits last up to thirty-nine weeks. An applicant for short term disability benefits must show that "following the onset of the injury or sickness, the Member is continuously unable to perform each and every duty of his or her Occupation."

After thirty-nine weeks, an employee still unable to work must apply separately for long-term disability benefits. Long-term benefits are granted under the Plan if "the Member is continuously unable to perform *any* occupation for which he or she is or may become qualified by reason of his or her education, training or experience" (emphasis added). The Plan stipulates that disability determinations for either long- or short-term benefits are to be "made by the Claims Administrator on the basis of objective medical evidence."

After first leaving work in May 1995 Jebian applied for and received short-term disability benefits. He applied for long-term benefits after the requisite thirty-nine weeks of short-term benefits. VPA initially denied the application, but on appeal reversed its decision. By the time of that re-

versal, Jebian had returned to work, so long-term benefits were granted retroactively only for the six-week period before Jebian returned to work.

Jebian shortly left work once again due to the same medical conditions. He tried to return to work in May 1997, but within a matter of weeks left work for a third time, this time not to return.

VPA found Jebian eligible for short-term disability benefits when he left work in June 1997. In February 1998, with the 39th week of his short-term benefits approaching, Jebian again applied for long-term benefits. VPA denied Jebian's application for long-term disability benefits on August 3, 1998.

VPA's letter of denial based its decision on two reports that it had commissioned concerning Jebian's condition: a "Work Capacities Assessment" conducted by physical therapists employed by HealthSouth, a company that conducts such physical assessments for insurers and employers, and an "Employability Assessment Report" conducted by a vocational consultant employed by Rehab West, a company that provides vocational assessments.

VPA's denial letter relied largely on HealthSouth's representation that Jebian could tolerate "sitting, walking, trunk bending, overhead reaching, squatting," and other functions, though the HealthSouth report had noted that Jebian had substantive limitations in his ability to carry out these functions. The letter also cited and adopted Rehab West's conclusion that Jebian was professionally and physically qualified to perform four occupations—user support analyst, data processing auditor, sales representative for computers and electronic data processing systems, and technical training instructor. The 1998 Rehab West report was identical to one that had formed the basis for the decision to deny Jebian long-term disability benefits two years earlier (a decision that, as noted, was retracted by VPA on appeal). Rehab West did not conduct its own medical exam of Jebian. Rather, the Rehab West report concluded, in one sentence,

that "[i]t also appears that these occupations are within his physical capabilities as per the medical reports provided." It is not clear from the record which medical documents were provided to Rehab West. Precisely the same sentence regarding medical reports had appeared in the 1996 Rehab West report, although Jebian's medical circumstances had changed greatly by 1998.[2] Further, the Rehab West report does not indicate that any of the jobs it suggests could be done by a person who can sit or stand for only limited time periods.[3]

In November 1998, Jebian appealed the denial of benefits. He argued that crucial records were not considered, that some medical records were misread, and that the alternative employment recommendations were based on erroneous readings of the medical information. Enclosed with his appeal was a letter from Dr. James Landes. Dr. Landes, who had examined Jebian in September 1998, reviewed medical records, the HealthSouth and Rehab West reports, and the denial letter; emphasized that Jebian is incapable of prolonged sitting or standing; and pointed out that the four jobs recommended by Rehab West all involve one or the other. Dr. Landes urged VPA to reconsider its decision.

Under the Plan's language, Jebian's "claim shall be deemed to have been denied on review" if VPA neither responds within sixty days nor informs the claimant that it could take up to sixty days longer to respond. On March 15, 1999, 119 days after receiving Jebian's appeal, VPA wrote to Jebian, responding to his objections but leaving the appeal pending to consider further medical documentation. VPA

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[2] In particular, Jebian had undergone two additional surgeries in the interim.

[3] Among the occupations suggested is "data processing auditor," a job that by Rehab West's account requires frequent computer use to analyze data and write reports. There is no indication in Rehab West's report that it took into account, regarding this suggested occupation or any of the others, the impact of Jebian's limitations on prolonged sitting.

wrote to Jebian again in June 1999, stating that it was still awaiting some medical records and that the appeal therefore remained pending.

On September 29, 1999, Jebian filed his complaint in district court. Only after that, on November 5, 1999, did VPA send Jebian a letter finally denying his claim for long-term disability benefits.

The district court reviewed VPA's decision for abuse of discretion and granted summary judgment to the Plan. We reverse. We conclude that the proper standard of review of VPA's decision in this case is *de novo,* and remand for reconsideration of Jebian's claim accordingly.

DISCUSSION

I

A challenge to an ERISA plan's denial of benefits is reviewed *de novo* "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). If a plan does grant such discretion, a reviewing court applies an "abuse of discretion" or what amounts to the same thing an "arbitrary and capricious" standard. *See Taft v. Equitable Life Assurance Soc'y*, 9 F.3d 1469, 1471 n.2 (9th Cir. 1994).

The plan before us explicitly grants discretion to decide appeals from denials of claims for benefits to the plan administrator. The pertinent language reads: "The Claims Administrator shall have the discretionary authority to construe the language of the plan and make the decision on review on behalf of the Organization."

The primary question before us, of first impression in this circuit, is whether a plan administrator's decision, otherwise within the administrator's discretion, can be accorded judicial deference when the purported final, discretionary decision is not made until after the claim is, according to both the terms of the plan and Department of Labor (DOL) regula-

tions, already automatically deemed denied on review. We conclude that where, according to plan and regulatory language, a claim is "deemed . . . denied" on review after the expiration of a given time period, there is no opportunity for the exercise of discretion and the denial is usually to be reviewed *de novo*. While deference may be due to a plan administrator that is engaged in a good faith attempt to comply with its deadlines when they lapse, this is not such a case.

A

Jebian's letter appealing the denial of benefits is dated November 11, 1998 and was received by VPA on November 16, 1998. VPA did not respond until March 15, 1999.[4] VPA's decision after that lapse in time was in violation of both the Department of Labor's (DOL) ERISA regulations and Plan language. Both the plan and a DOL regulation, 29 C.F.R. § 2560.503-1(h)(1)(i) (1998),[5] required some written notice in response to an appeal within sixty days—even if

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[4] Contrary to the dissent's suggestion (*post* at 16665-66), Jebian did not prior to March 15, 1999 refuse to provide any requested medical records. The records were not *requested* until March 15, 1999, one day before the second extended sixty-day period for deciding the appeal ran out. There was plenty of time for VPA to have made the request, and for Jebian to have replied, before the first—let alone the second—sixty-day period expired.

[5] We refer to the Code of Federal Regulations as of 1998, the year Jebian's claim was filed. The pertinent regulation, 29 C.F.R. § 2560, first promulgated in 1977, was amended in 2000. *See* Pension and Welfare Benefits Administration, 65 Fed. Reg. 70,246 (Nov. 21, 2000). The alterations apply to claims filed on or after January 1, 2002. 29 C.F.R. § 2560.503-1(o) (2002). The new regulation shortens from sixty days to forty-five the time allowed for initial responses to appeals from denials of disability benefits. 29 C.F.R. § 2560.503-1(i)(3)(i) (2002). Excised from the new regulation is the provision that transgressions of time limitations will result in the claim being "deemed denied." *See* 29 C.F.R. § 2560.503-1(h) (2002).

only to establish an extension, available only where "special circumstances . . . require." *Id.* The Plan also stated:

> If a claimant has not received written notice that additional time is required for review within sixty (60) days of the date his or her request for review is received by the Claims Administrator, the claim shall be deemed to have been denied on review.

See also 29 C.F.R. § 2560.503-1(h)(4) (1998) (similarly providing that appeals neither timely decided nor extended are deemed denied). So any appeal not responded to within the requisite time limit was deemed denied.

The regulation and the Plan further required in all instances a *final* determination within 120 days (sixty days plus the sixty-day allowable extension) of the appeal. Again, the regulation and the Plan deemed any claim denied unless there was a final determination within that time limit. The Plan stated:

> If a claimant receives proper and timely notice that additional time is required for review, but does not receive written notice of the Claims Administrator's decision with respect to his or her claim within one hundred twenty (120) days after the date the Claims Administrator receives the request for review, the claim shall be deemed to have been denied on review.

See also 29 C.F.R. § 2560.503-1(h)(4) (1998) (similarly providing that claims neither timely decided nor extended on review are deemed denied).

VPA gave no written notice to Jebian between the filing of his appeal and its March 15 letter, written a day before the 120-day limit expired. The letter responded to Jebian's objections but left the case open to consider further medical documentation, without specifying until later what information might be useful. Thus even if we ignore the initial failure to respond, according to the regulation and the Plan's terms, Jebian's claim, the appeal of which was not decided within 120 days, was deemed denied on March 16.

VPA asks us, in effect, to ignore the "deemed . . . denied" language in the regulation and the Plan and treat its March 15 letter as a good faith component of the "meaningful dialogue between ERISA plan administrators and their beneficiaries." *Booton v. Lockheed Med. Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997). By engaging in such dialogue, VPA argues, it was in "substantial compliance" with the sixty/120-day deadline regime, *see Gilbertson v. Allied Signal Inc.*, 328 F.3d 625, 634 (10th Cir. 2003), and thereby retained its discretion to determine the claim. We do not agree.

Firestone directs us to abide by the principle from trust law that "a court of equity will not interfere to control" trustees "in the exercise of a *discretion vested in them by the instrument* under which they act." *Firestone*, 489 U.S. at 111 (internal quotation marks and citation omitted). The instrument in this case does vest discretion, but the same instrument and the regulation that governed it set time boundaries within which that discretion must be exercised. We are just as bound by the Plan language deeming denial in the event that time limits are exceeded as we are bound by the Plan language that grants discretion to the Plan administrator. Decisions made outside the boundaries of conferred discretion are not exercises of discretion, the substance of the decisions notwithstanding.

More practically, if we were to accept VPA's suggestion, use of the *language* of discretion—that is, providing reasons and asking for more information—would become a talisman by which administrators could ensure deference even when they are expressly precluded by the trust agreement from exercising discretion because the time for doing so has passed. Also, a contrary rule would allow claimants, who are entitled to sue once a claim had been "deemed denied," to be "sandbagged" by a rationale the plan administrator adduces only after the suit has commenced. *See Marolt v. Alliant Techsystems, Inc.*, 146 F.3d 617, 620 (8th Cir. 1998). Our refusal to subject claimants to that eventuality parallels the general rule that "an agency's order must be up-

held, if at all, on the same basis articulated in the order by the agency itself," not a subsequent rationale articulated by counsel. *Federal Power Comm'n v. Texaco, Inc.*, 417 U.S. 380, 397 (1974) (internal quotation marks and citation omitted).

Analogously to the rule we adopt here, this court has interpreted a statute that imposes a deadline for United States Fish and Wildlife Service action to preclude the agency from gaining additional time to make discretionary findings. *See Biodiversity Legal Found. v. Badgley*, 309 F.3d 1166, 1178 (9th Cir. 2002) ("The exercise of discretion is foreclosed when statutorily imposed deadlines are not met."). Our holding is consistent as well with the rule in at least three other circuits on a similar, although separate, issue. Those circuits considered whether deference is owed to a decision to revoke benefits when that decision is made by a body other than the one authorized by the procedures set forth in a benefits plan. *Sanford v. Harvard Indus.*, 262 F.3d 590, 597 (6th Cir. 2001); *Sharkey v. Ultramar Energy*, 70 F.3d 226, 229 (2d Cir. 1995); *Rodriguez-Abreu v. Chase Manhattan Bank*, 986 F.2d 580, 584 (1st Cir. 1993). All three circuits concluded that no deference is owed under these circumstances.

The principle underlying these wrong decision-maker cases is that although *Firestone* directs courts to defer to the decisions of plans in which their language grants discretionary authority, that deference applies only when the decision is made by the body vested with discretion. "When an unauthorized body that does not have fiduciary discretion to determine benefits eligibility renders such a decision . . . deferential review is not warranted." *Sanford*, 262 F.3d at 597. Similarly, we will not defer when a decision is, under the Plan, necessarily the mechanical result of a time expiration rather than an exercise of discretion.

We note that the principle we apply in this case may apply more generally to decisions made in violation of procedures prescribed by applicable regulations or the plan itself. *Sanford* explained that "[t]he logic behind [the cases denying deference to plan decisions made by a body other than the

one granted discretion] is that deferential review under the 'arbitrary and capricious' standard is merited for decisions regarding benefits *when they are made in compliance with plan procedures*" (emphasis added). 262 F.3d at 597. When decisions are not in compliance with regulatory and plan procedures, deference may not be warranted.

We have held previously that procedural violations can affect the merits determination concerning whether an abuse of discretion has taken place. *Blau v. Del Monte Corp.*, 748 F.2d 1348 (9th Cir. 1984) *(abrogation on other grounds recognized by Dytrt v. Mountain State Tel. & Tel. Co.*, 921 F.2d 889, 894 n.4 (9th Cir. 1990)), ruled that "[o]rdinarily, a claimant who suffers because of a fiduciary's failure to comply with ERISA's procedural requirements is entitled to no substantive remedy," but that if procedural violations result in "substantive harm," then "a court must consider [such violations] in determining whether the decision to deny benefits in a particular case was arbitrary and capricious." *Blau*, 748 F.2d at 1353-54. *Blau* left open the question whether procedural violations influence the standard of review. 748 F.2d at 1353. Moreover, *Blau* was decided before *Firestone*, when our default standard for reviewing ERISA plan decisions was "arbitrary and capricious" rather than *de novo.*

For present purposes, however, we leave the more general issue open and decide only that where the plan itself provides that a particular procedural violation results in an automatic decision rather than one calling for the exercise of the administrator's discretion, that provision is as enforceable as the provision giving the administrator discretionary authority under other circumstances. Deference to an exercise of discretion requires discretion actually to have been exercised. *See Mansker v. TMG Life Ins. Co.*, 54 F.3d 1322, 1328 (8th Cir. 1995) ("[W]here an ERISA plan gives a plan administrator or fiduciary discretion to decide certain issues, the fact that the administrator or fiduciary fails to address or decide those issues does not exempt those issues from de novo review by the district court on summary judgment."). Deemed denials are not exercises of discre-

tion. They are therefore undeserving of deference under *Firestone*, and a *de novo* standard of review applies.[6]

B

The precise question in this case has not had extensive treatment in other circuits, and conclusions in similar cases vary. In *Gritzer v. CBS, Inc.*, 275 F.3d 291, 296 (3d Cir. 2002), the Third Circuit applied *de novo* review to a plan that otherwise granted discretion to the administration because under the plan the employee pension claim was deemed denied. Turning to the analogy between ERISA plans and trusts, the Third Circuit stated: "Where a trustee fails to act or to exercise his or her discretion, *de novo* re-

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6 As should be apparent from the discussion in the text, the dissent's analysis of the standard of review is incorrect for two reasons.

First, the dissent entirely ignores the fact that the limitation on the exercise of discretion upon which we rely *is expressly contained in the plan itself*. Thus, the question is not whether "VPA relinquished the discretion granted it in the plan" by failing to respond to the appeal in a timely manner (*post* at 16661), but whether VPA is entitled to be regarded as having exercised discretion in deciding the appeal even though *the Plan itself* withdraws that discretion to decide and substitutes an automatic, unreasoned decision when the deadline is not met.

Second, the question here is not whether Jebian is entitled to a "substantive remedy," *Blau*, 748 F.2d at 1353, for the failure to decide the appeal in accord with ERISA. We do not decide that Jebian is to be awarded benefits, damages, or any other relief because VPA violated ERISA. Instead, we simply enforce *the Plan's own terms* regarding whether VPA retained discretionary authority over the appeal once the time limit had lapsed, and apply a *de novo* standard of review to decide *whether* Jebian is entitled to benefits. The line of post-*Blau* cases the dissent relies upon, which involved claims that benefits should be due because of procedural violations of the statute or regulations, are therefore inapposite. *See, e.g., Parker v. BankAmerica Corp.*, 50 F.3d 757, 768 (9th Cir. 1995) (rejecting argument that employees should recover benefits because the administration failed to provide them with a copy of the plan on request).

view is appropriate because the trustee has forfeited the privilege to apply his or her discretion; it is the trustee's analysis, not his or her right to use discretion or a mere arbitrary denial, to which a court should defer." *Id.* (citation omitted). *Gritzer* was a slightly different case from ours, however, because there the plan did not respond at all, either early or late, to the employees' claims.

In a case more akin to ours, the Tenth Circuit recently held, in *Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625, 631 (10th Cir. 2003), that "*Firestone* seems to require" *de novo* review of "deemed" denials. "[T]o be entitled to deferential review, not only must the administrator be given discretion by the plan, but the administrator's decision in a given case must be a valid exercise of that discretion." *Id. Gilbertson* noted it was "in harmony" with our initial opinion, since withdrawn, in this case. *Id.* at 632.[7]

The Fifth Circuit stated without discussion in *Southern Farm Bureau Life Insurance Co. v. Moore*, 993 F.2d 98, 101 (5th Cir. 1993), that "[i]n our view, the standard of review is no different whether the claim is actually denied or is deemed denied." In *Daniel v. Eaton Corp.*, 839 F.2d 263, 267 (6th Cir. 1988), which was decided before *Firestone*, the Sixth Circuit stated that "the standard of review is no different whether the appeal is actually denied or is deemed denied." More recently, however, the Sixth Circuit, while noting *Daniel*, commented that "there is undeniable logic in the view that a plan administrator should forfeit deferential review by failing to exercise its discretion in a timely manner." *Universal Hosps. of Cleveland v. Emerson Elec. Co.*, 202 F.3d 839, 846 n.3 (6th Cir. 2000). *Universal Hospitals* left open the standard of review question, as it did not matter to the result. *Id.*

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7 We discuss *Gilbertson* further below.

Finally, in *McGarrah v. Hartford Life Ins. Co.*, 234 F.3d 1026 (8th Cir. 2000), the Eighth Circuit refused to consider the failure to respond to an appeal as affecting the standard of review. There is nothing in *McGarrah*, however, indicating that the plan in question contained the "deemed . . . denied" language at issue here. Further, here, the Plan administrator did purport to decide the appeal, albeit late, and is asking us to defer to its decision on review rather than to its original denial of benefits (which did not, of course, consider Jebian's submissions on appeal). *See Gilbertson*, 328 F.3d at 633 (arguing that *McGarrah* should be followed, if at all, only where "the claimant does not provide meaningful new evidence or raise significant new issues in the appeal").

Of these cases, we find the reasoning in *Gilbertson* and the observation in *Universal Hospitals* most illuminating, for all the reasons already surveyed.

C

VPA maintains that even if *de novo* review applies to deemed denials where the administrator has wholly failed to comply with the Plan's or regulations' procedures, VPA deserves deference here because it was engaged in an ongoing "meaningful dialogue" with Jebian during the 120-day decision period. *See Booton v. Lockheed Med. Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997). Just as there is good reason to avoid giving talismanic power to the language of discretion, there is reason as well to avoid endowing the sixty or 120-day deadlines with such significance that manipulation of deadlines could be employed tactically by either ERISA claimants or plan administrators. As the Tenth Circuit recently noted in *Gilbertson*, ERISA is designed to promote a good-faith bilateral exchange of information on the merits of claims, not hasty decisionmaking by administrators so as to slip under the 120-day wire or delay by claimants so as to ensure a deemed denial. *Gilbertson*, 328 F.3d at 635. We agree with the *Gilbertson* court that "inconsequential violations of the deadlines . . . would not entitle the claimant to *de novo* review," *id.*, "in the context of an ongoing, good

faith exchange of information between the administrator and the claimant." *Id.*

The procedural violations here were far from "inconsequential," however, and there was no such "ongoing, good faith exchange." Under the Plan and the regulations then in force, VPA should have either decided the appeal within sixty days or informed Jebian that, because of "special circumstances," it needed sixty more days. *See* 29 C.F.R. § 2560.503-1(h)(1)(i). It did neither. Nor did VPA request any further information until the 119th day, one day short of the 120-day deadline. One hundred nineteen days of "radio silence," *Gilbertson*, 328 F.3d at 636, is neither productive nor reasonably informative to the claimant. Accordingly, while our holding regarding the appropriate standard of review on "deemed denied" claims may be tempered in cases where a delinquent plan is nonetheless in substantial compliance with prescribed procedures, this is not such a case.

Because we recognize the same caveat *Gilbertson* adopted, we also reject VPA's more general policy argument that the prospect of *de novo* review for claims deemed denied through administrative inaction is apt to lead to more denials, as administrators precipitously decide claims before sixty (or 120) days have lapsed in order to secure deferential review. Absent unusual circumstances, an administrator engaged in a genuine, productive, ongoing dialogue that substantially complies with a plan's and the regulations' timelines should remain entitled to whatever discretion the plan documentation gives it. Hence, administrators in substantial compliance have no need to rush to judgment. We also note that, even for timely denials on the merits, "it is an abuse of discretion for ERISA plan administrators to render decisions without any explanation." *Bendixen v. Standard Ins. Co.*, 185 F.3d 939 (9th Cir. 1999) (citing *Eley v. Boeing Co.*, 945 F.2d 276, 279 (9th Cir. 1991)). The prospect of *de novo* review of untimely decisions should therefore only spur administrators into producing timely, reasoned decisions—exactly what ERISA aims to achieve.

II

On the merits of the denial of benefits, Jebian points out that although the Plan requires that disability determinations be based on "objective medical evidence," VPA never had him examined by, or his medical records reviewed by, a doctor. Neither of the evaluations upon which VPA based its decision was prepared by a doctor. The HealthSouth assessment was conducted by physical therapists. The Rehab West report was prepared by a "vocational consultant."

Rehab West found Jebian to be capable of four occupations. The report first describes those occupations as ones "Jebian can do within his education and vocational background." The report adds: "It also appears that these occupations are within his physical capabilities as per the medical records provided," but, as noted, it is not clear from the record which medical records were reviewed by Rehab West, and Rehab West issued identical reports in 1996 and 1998 despite changes in Jebian's medical circumstances.

Jebian stresses, furthermore, that VPA's decision is in tension with the opinions of several doctors, including the doctors who treated him, all of whom agree that Jebian can neither sit nor stand except for a very short time and is therefore permanently disabled. Dr. James Stark examined Jebian at Hewlett Packard's request with regard to a workers' compensation claim. Dr. Stark wrote in October 1995, after Jebian had undergone his second back surgery, that "Mr. Jebian is not capable of working at this time because of his sitting and standing limitations. It is not clear whether he will ever be able to compete in the open labor market because of pain related physical limitations."

Dr. Lu, who has treated Jebian since February 1995, filled out a "Physician's Certification of Disability" for Jebian in September 1997. Dr. Lu noted on that form that Jebian "has tried to RTW [return to work] twice, but was unable to tolerate sitting more than a few minutes at a time, or standing." Dr. Lu filled out another Hewlett Packard Company form on January 30, 1998. This time Dr. Lu checked a

box stating that his patient is "now totally disabled from any other work." Dr. Lu checked another box indicating that he did not "expect a fundamental or marked change in the future." Dr. Lu commented on the form that Jebian is subject to a "[s]evere limitation of sitting and standing ([maximum 5 minutes] at a time)" and "has too much pain to sit or stand more than a few minutes at a time."

Dr. Landes, who began treating Jebian in September 1998 after Jebian moved to a new area, stated in his November 1998 letter in support of Jebian's appeal that patients with his condition "are permanently precluded from activities requiring . . . prolonged sitting or prolonged standing," and that "[h]is current physical exam findings confirm the information in the records and support his claim of permanent disability, limiting him to sedentary work." Dr. Landes also reviewed in his letter the particular occupations cited by the Rehab West report, concluding that Jebian could not stand or sit for sufficiently sustained periods to perform the jobs recommended. Even the HealthSouth Report relied upon by VPA, for that matter, seems to indicate that Jebian can only sit for twenty minutes at a time and stand for thirty minutes at a time. Additionally, there was medical corroboration of Jebian's constant pain, in the form of extensive records concerning his participation in a study, supervised by Dr. Lacy, of a new pain medication. To obtain the medication, Jebian was required to keep a diary and visit Dr. Lacy's office frequently, which he did.

VPA chose, despite this evidence, to deny Jebian benefits in accord with the suggestion of the Rehab West report that there were four occupations in the market that Jebian was capable of performing. The district court found that VPA did not abuse its discretion in doing so.

In light of this record evidence, applying *de novo* review to the district court's grant of summary judgment leads us to conclude that there is a genuine issue of fact concerning whether Jebian is disabled. *See Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1094 (9th Cir. 1999) (en banc). There is medical evidence in the record from Jebian's treating physi-

cians documenting the physiological basis for his back pain; the aggressive surgical treatment he underwent; the persistence of the pain, necessitating continued treatment with innovative painkillers; and professional assessments that Jebian was functionally precluded from standing or sitting for more than a few minutes at a time.[8]

VPA argues that Jebian's extensive medical evidence does not pertain to the relevant moment, which is the end of the temporary disability benefit period, March 3, 1998. A trier of fact, reviewing the entire record submitted to VPA, could conclude otherwise. For example, although VPA rejected records from 1995 as "immaterial" to Jebian's disability in March 1998, in fact those records are pertinent, although certainly not determinative. They both trace the history of Jebian's back injury and indicate that it is capable of

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[8] After the district court granted VPA summary judgment, the Ninth Circuit ruled that ERISA plan decisions were to be governed by the "treating physician rule" that, in Social Security disability cases, grants special weight to the opinion of a claimant's own doctor. *See Regula v. Delta Family-Care Survivorship Plan*, 266 F.3d 1130, 1139 (9th Cir. 2001). The Supreme Court, however, recently rejected the extension of a treating physician rule to disputed ERISA claims. *See Black & Decker Disability Plan v. Nord*, 123 S.Ct. 1965, 1969 (2003). On remand, the district court is therefore not to apply the treating physician rule. Of course, the opinions of Jebian's doctors may (indeed, must) be accorded whatever weight they merit. Even without an "automatic[ ]" rule of deference, "[p]lan administrators . . . may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician." *Id.* at 1966.

On *de novo* review, a district court may, in conducting its independent evaluation of the evidence in the administrative record, take cognizance of the fact (if it is a fact in the particular case) that a given treating physician has "a greater opportunity to know and observe the patient" than a physician retained by the plan administrator. *Id.* at 1971 (quoting *Regula*, 266 F.3d at 1139 (internal quotation marks and citations omitted)).

causing total disability. Jebian's treating physician, Dr. Lu, certified on January 30, 1998, that Jebian remained severely functionally limited due to his back injury. Dr. Lu's opinion was based on a June 1997 office visit and over two years' experience in treating Jebian's back ailment. Finally, Dr. Landes, contrary to the district court's understanding, did examine Jebian himself, in September 1998, and based his October 1998 letter in part on that examination.

A trier of fact, reviewing the evidence before VPA *de novo*, could infer that functional limitations confirmed by treating physicians in June 1997, May 1998, and September 1998, more likely than not existed in March 1998 as well, rather than disappearing before March 1998 and reappearing thereafter.

While under an abuse of discretion standard our review is limited to the record before the plan administrator, *McKenzie v. General Tel. Co.*, 41 F.3d 1310, 1316 (9th Cir. 1994), this limitation does not apply to *de novo* review. *Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan*, 46 F.3d 938, 944 (9th Cir. 1995) (on remand, district court has discretion to take additional evidence "when circumstances clearly establish that additional evidence is necessary to conduct an adequate *de novo* review of the benefit decision").[9] Now that we have clarified that *de novo* re-

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[9] We take it that the dissent's contrary statement, citing *Kearney*, as well as its derivative conclusion that we should direct that the district court remand the decision to the plan administrator, assume an abuse of discretion standard of review, the central point upon which we disagree. *Mongeluzo* makes quite clear, as does *Kearney*, that where review is *de novo*, the record is not necessarily so limited. *Mongeluzo*, 46 F.3d at 944; *Kearney*, 175 F.3d at 1091-92. Similarly, the holding in *Saffle v. Sierra Pac. Power Co. Bargaining Unit Long Term Disability Income Plan*, 85 F.3d 455 (9th Cir. 1996), regarding the need to remand to the administrator who applied the wrong legal standard is explicitly limited to the abuse of discretion context. *Id.* at 461 (recognizing that *Mongeluzo*, applying a *de novo* standard, remanded to the district court "for a

[Footnote continued on next page]

view is appropriate, the trial court must have an opportunity to determined whether to admit such additional evidence so as to "enable the full exercise of informed and independent judgment." *Id.* at 943; *see also id.* at 944 (a "change in the posture of the case" can justify taking additional evidence on *de novo* review). We therefore remand to the district court to allow consideration of further developments of the record under the *Mongeluzo* standard and *de novo* review of the denial of the benefits claim.[10]

[Footnote continued from previous page]
factual determination under a proper construction of the terms of the plan," but holding that "remand [to the administrator] for reevaluation of the merits of a claim is the correct course to follow when an ERISA plan administrator, with discretion to apply a plan, has misconstrued the Plan and applied a wrong standard to a benefits determination.").

10 This case, we note, is in a somewhat different posture than *Kearney*, because the district court originally reviewed the existing record on an abuse of discretion rather than a *de novo* basis. Consequently, even if the district court does not admit any further evidence, its role in conducting a bench trial on the entire record compiled by VPA will be entirely different from its previous deferential review. *Compare Kearney,* 175 F.3d at 1095 (opinion of Kleinfeld, J.) (even where district court decided summary judgment motion on the same review standard, it makes sense to remand for a bench trial on the record because "[t]he district judge will be asking a different question" and will have to make factual findings) *with id.* at 1099 (Reinhardt, J., concurring in the result) ("it would make no sense to remand" to review the same record *de novo* on the merits as was reviewed de novo on summary judgment). There is, consequently, no need to decide the question arguably left open in *Kearney* concerning the necessity for a remand under the circumstances of that case. *Compare id.* at 1094-95 (opinion of Kleinfeld, J.) (a majority of the court approved permitting the district court on remand to try the case on the administrative record) *with id.* at 1096 (opinion of B. Fletcher, J.) (characterizing Judge Kleinfeld's opinion as one for a plurality), *and id.* at 1097 (opinion of Reinhardt, J.) (agreeing with Judge B. Fletcher's characterization of Judge Kleinfeld's opinion as a plurality opinion, "at least with respect to Parts III & IV").

CONCLUSION

We reverse the grant of summary judgment to VPA and remand for proceedings consistent with this opinion.

REVERSED and REMANDED.

TASHIMA, Circuit Judge, dissenting:

I dissent because the majority forfeits an independent ERISA administrator's plan-given authority to exercise its discretion when ruling on a plan member's claim, simply because the administrator was late in ruling on a claim for benefits and, in doing so, creates an inter-circuit conflict. The majority acknowledges that the plan "explicitly grants discretion to decide appeals from denials of claims for benefits to the plan administrator." Maj. op. at 16642. Further, the record reveals that the independent plan administrator, Voluntary Plan Administrator ("VPA"), did exercise its discretion in denying Jebian's appeal. To apply the non-deferential, de novo standard of review solely because of a procedural irregularity is an extreme measure warranted neither by the facts of this case nor by the cases on which the majority relies. As I explain below, all of those cases involved circumstances very different from those presented here. On the contrary, the majority's conclusion conflicts with all but one of the decisions that have dealt with the precise issue we face, as well as with the reasoning of our own precedent regarding the effect of procedural violations.

Jebian's letter appealing the denial of benefits is dated November 11, 1998, and was received by VPA on November 16, 1998. VPA responded on March 15, 1999, with a letter denying some of Jebian's claims and asking for further information regarding two of his claims. The letter explained in detail the reasons for VPA's decision. This letter was sent after the 60-day period required by 29 C.F.R. § 2560.503-1(h)(4)(i), but before the 120-day limit. On June 11, 1999, VPA wrote to Jebian to inform him that it had received some, but not all, of the medical records it had requested, and that

the medical offices stated that Jebian had not returned the medical authorization forms they needed in order to release the rest of the records. VPA indicated that it would assume the claims were pending until it received the records. Jebian responded by filing this action on September 20, 1999. On November 5, 1999, VPA sent Jebian a letter again explaining the reasons for the denial of benefits and giving further explanations based on the records it had received.

The cases cited by the majority do not support its conclusion to strip the plan administrator of its discretion. For example, in *Rodriguez-Abreu v. Chase Manhattan Bank*, 986 F.2d 580 (1st Cir. 1993), the decision regarding benefits was made by someone who was not authorized by the plan to make that decision. Likewise, in *Sanford v. Harvard Indus., Inc.*, 262 F.3d 590 (6th Cir. 2001), the court affirmed the district court's determination that it was not the authorized party that made the benefits determination, but "the company at a meeting prompted by a union grievance held under the auspices of the [collective bargaining agreement]." *Id.* at 596-97. Thus, in both *Rodriguez-Abreu* and *Sanford*, unlike this case, the decision regarding benefits was made by someone who was not given discretionary authority by the plan. The First and Sixth Circuits therefore properly upheld the district courts' use of the de novo standard of review rather than the abuse of discretion standard. *Id.*; *Rodriguez-Abreu*, 986 F.2d at 584. Finally, in *Sharkey v. Ultramar Energy Ltd.*, *70* F.3d 226, 229-30 (2d Cir. 1995), the court stated that the denial of benefits is reviewed de novo if an unauthorized party makes the determination, but found that there was insufficient evidence of who actually made the determination in order to uphold the grant of summary judgment. It therefore reversed the grant of summary judgment and remanded. *Id.* at 230.

Unlike *Rodriguez-Abreu*, *Sanford*, and *Sharkey*, the instant case does not involve an unauthorized party making the benefits determination. VPA, as the majority concedes, is the party granted the discretionary authority by the plan to decide claim appeals. In cases in which the party that is given discretionary authority by the plan did not actually exercise its

discretion, such as those cited by the majority, it makes sense to apply the de novo standard of review. Here, however, the discretion was exercised by the party in whom it was vested by the plan, VPA, albeit in an untimely manner.[1]

The Eighth Circuit addressed the precise question we face in a case with facts similar to those presented here, *McGarrah v. Hartford Life Ins. Co.*, 234 F.3d 1026 (8th Cir. 2000). In *McGarrah*, the Eighth Circuit rejected the claimant's argument that the insurance company's failure to respond to his appeal from an adverse decision entitled the claimant to a less deferential standard of review. *Id.* at 1030-31. The insurance company in *McGarrah* completely failed to respond to the claimant's appeal. The court acknowledged that the company's failure to respond was "a serious procedural irregularity." *Id.* at 1031 (citing 29 C.F.R. § 2560.503-1(h)(3)). It relied, however, on its decision in *Buttram v. Cent. States, S.E. & S.W. Areas Health & Welfare Fund*, 76 F.3d 896 (8th Cir. 1996), in which it stated that procedural irregularities "must have some connection to the substantive decision reached; i.e., they must cause the actual decision to be a breach of the plan trustee's fiduciary obligations." *Id.* at 901. Reasoning that the insurance company had made a thorough investigation and adequately explained the basis for its decision, the court in *McGarrah* concluded that the claimant failed to meet his burden of presenting evidence that the irregularity raised serious doubts about the integrity of the decision making process. *McGarrah*, 234 F.3d at 1031. The court therefore held that the district court properly applied

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[1] The majority's emphasis on the fact that it was the plan itself that deemed the claim denied, not just the regulations, is irrelevant because the plan merely mirrored the language in the regulation in force at the time, 29 C.F.R. § 2560.503-1(h) (1999). Section 2560.503-1 was amended in 2000, removing the language stating that a claim is deemed denied on review if the claimant does not receive written notice within sixty or 120 days. *See* 65 Fed. Reg. 70246, 70265, 70268-69 (Nov. 21, 2000).

the deferential abuse of discretion standard.[2] *Id.*; *see also Tillery v. Hoffman Enclosures, Inc.*, 280 F.3d 1192, 1198-99 (8th Cir. 2002) (upholding the district court's decision to review the decision for an abuse of discretion where the administrator's "failure to provide [the beneficiaries] with timely notice of the denial and of their appeal rights" resulted in a procedural irregularity, but the irregularity did not "so undermine the decision of the plan administrator as to render it suspect"); *Clapp v. Citibank, N.A. Disability Plan (501)*, 262 F.3d 820, 827-28 (8th Cir. 2001) (stating that a "sliding-scale" standard of review is appropriate only if the claimant presents material, probative evidence demonstrating a palpable conflict of interest or serious procedural irregularity that caused a serious breach of fiduciary duty, and concluding that a less deferential standard of review was not warranted).

Here, VPA's response detailed the reasons for the denial of Jebian's appeal. There is no evidence in the record that VPA relinquished the discretion granted it in the plan

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2 The majority dismisses *McGarrah* on the basis that "[t]here is nothing in *McGarrah* . . . indicating that the plan in question contained the 'deemed . . . denied' language at issue here." Maj. op. at 16650. The same regulations as were in force in the instant case, containing the "deemed denied" language, were in force at the time of the appeal of benefits in *McGarrah*. Thus, the appeal in *McGarrah* presumably was also deemed denied, at least by operation of the regulations, if not also by the plan itself, a question not addressed by *McGarrah*. Whether it is the regulation or the plan, or both, as in the instant case, that deems the claim denied, is irrelevant. The question is whether the import of the "deemed denied" language is that discretion is completely removed from the administrator, as the majority concludes, or whether the untimeliness is merely a procedural violation. Where, as here, the administrator has exercised its discretion, and the claimant has presented no evidence that the timing of the decision prejudiced him in any way, it does not make sense to strip the administrator of its authority, regardless of whether the "deemed denied" language is contained in the plan or the regulations.

or that the untimeliness of its response raised doubts about the integrity of the decision-making process.[3]

"Ordinarily, a claimant who suffers because of a fiduciary's failure to comply with ERISA's procedural requirements is entitled to no substantive remedy." *Blau v. Del Monte Corp.*, 748 F.2d 1348, 1353 (9th Cir. 1985) (citation omitted); *see also Kent v. United of Omaha Life Ins. Co.*, 96 F.3d 803, 807 (6th Cir. 1996) ("Generally, the courts have recognized in E.R.I.S.A. cases that procedural violations entail substantive remedies only when some useful purpose would be served."). As the majority observes, the question of whether procedural violations influence the standard of review was left open in *Blau*.[4] In *Blau*, "there was no summary plan description, no claims procedure, and no provision to inform participants in writing of anything;" in short, the employer "failed to comply with virtually every applicable mandate of ERISA." 748 F.2d at 1353. We reasoned that the egregious procedural violations "work[ed] a substantive harm" by "alter[ing] the substantive relationship between employer and employee that disclosure, reporting and fiduciary duties sought to balance somewhat more equally." *Id.* at 1354. "Thus, in reviewing an administrator's decision, a court must consider continuing procedural viola-

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[3] Both *McGarrah* and the instant case are distinguishable from *Gritzer v. CBS, Inc.*, 275 F.3d 291 (3d Cir. 2002), cited by the majority, at 16649, because, in *Gritzer*, the plan administrator "never made any effort to analyze" the appellants' initial claim for benefits, "much less to advise them of what that analysis disclosed," until after the litigation was filed. *Id.* at 295.

[4] As the majority notes, *Blau* was decided before *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), when the default standard of review of administrator's decisions under ERISA was the deferential "arbitrary" or "capricious" standard. *Blau*, 748 F.2d at 1353. In the instant case, however, the default standard of review would be the abuse of discretion standard as well, because of the explicit grant of discretionary authority contained in the plan.

tions in determining whether the decision to deny benefits in a particular case was arbitrary and capricious." *Id.*

While *Blau* left the question open, we have since required claimants to show that a violation of ERISA's procedural requirements "'caused a substantive violation or themselves worked a substantive harm.'" *Parker v. BankAmerica Corp.*, 50 F.3d 757, 769 (9th Cir. 1995) (quoting *Bogue v. Ampex Corp.*, 976 F.2d 1319, 1326 n.33 (9th Cir. 1992)); *McKenzie v. Gen. Tel. Co.*, 41 F.3d 1310, 1314-16 (9th Cir. 1994) (reasoning that the insurance company's procedural violation did not prejudice the claimant's "opportunity to obtain a full and fair review of his claim," and consequently affirming the district court's holding that the violation did not cause the claimant substantive harm); *Bogue,* 976 F.2d at 1326 (concluding that the claimant "ha[d] not met his requirement of showing that any procedural defects caused him substantive harm or involved a substantive violation of ERISA"). Thus, even though *Blau* and its progeny deal with whether the claimant was entitled to a substantive remedy, rather than whether a less deferential standard of review should apply, the question we faced in *Blau is* the same as that we face here-that is, what should be the consequence of a procedural violation?

Similar to *Blau*, our sister circuits have adopted a rule of substantial compliance in determining whether violations of 29 C.F.R. § 2560.503-1's claims procedures warrant relief; that is, a decision regarding benefits will not be upset for procedural violations if the company has substantially complied with procedural requirements such that the claimant has "all the necessary information at a time when the participant still has a meaningful opportunity for appeal and for full and fair review." *Schleibaum v. Kmart Corp.*, 153 F.3d 496, 499 (7th Cir. 1998) (citations omitted); *see, e.g.*, *Perrino v. S. Bell Tel. & Tel. Co.*, 209 F.3d 1309, 1318 (11th Cir. 2000) (stating that claimants should not be able to avoid the exhaustion requirement if technical deficiencies in a claims procedure do not hinder effective administrative review of their claims); *Terry v. Bayer Corp.*, 145 F.3d 28, 39 (1st Cir.

1998) (rejecting a claim for relief from an adverse decision regarding benefits where no prejudice resulted from inadequate notice of the denial, stating that "ERISA's notice requirements are not meant to create a system of strict liability for formal notice failures"); *Heller v. Fortis Benefits Ins. Co.*, 142 F.3d 487, 492-93 (D.C. Cir. 1998) (reasoning that, "although the initial letter from [the insurance company] informing [the claimant] of the denial of her disability benefits did not conform to the requirements of the regulations," the communication between the company, the claimant, and her lawyer insured that she understood the reasons for the denial of benefits and her right to appeal the decision); *Kent*, 96 F.3d at 807-08 (adopting the rule that a decision will be upheld even if procedures have been violated, if the claimant is "notified of the reasons for the denial of the claim and [has] a fair opportunity for review"); *Hines v. Mass. Mut. Life Ins. Co.*, 43 F.3d 207, 211 (5th Cir. 1995) (stating that the "[f]ailure to fulfill procedural requirements generally does not give rise to a substantive damage remedy," except "when the violations are continuous and amount to substantive harm," and citing *Blau); Sheppard & Enoch Pratt Hosp., Inc. v. Travelers Ins.* Co., 32 F.3d 120, 127 (4th Cir. 1994) (finding no prejudice in a plan administrator's violations of 29 C.F.R. § 2560.503-1's requirements of a timely and specific response, stating that the notice substantially complied with the regulation); *Donato v. Metro. Life Ins.* Co., 19 F.3d 375, 382-83 (7th Cir. 1994) (stating that substantial compliance with the regulations is sufficient, and concluding that the claimant had received information sufficient to permit effective review).

Thus, although *Blau* left open the issue of the applicable standard of review when ERISA's procedural requirements have been violated, it also set forth the principle that the claimant must show some type of prejudice or harm that results from a procedural violation of ERISA. We have relied on that principle in affirming benefits decisions, *see, e.g.*, *Parker*, 50 F.3d at 769; *McKenzie*, 41 F.3d at 1315-16, and other circuits have engaged in a similar analysis in determin-

ing the effect of procedural violations of ERISA, as the cases cited above demonstrate.

Our line of cases following *Blau* firmly establishes the law of the circuit that a showing of prejudice from a procedural violation of ERISA, *i.e.*, that the violation caused the claimant substantive harm, is required before relief can be granted based on such a violation. *Parker*, 50 F.3d at 769; *McKenzie*, 41 F.3d at 1314-16; *Bogue*, 976 F.2d at 1326 & n.33. The majority's decision today literally disregards circuit precedent that is clearly relevant to the instant case without so much as even mentioning those cases.[5]

The majority relies on *Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625 (10th Cir. 2003), in which the Tenth Circuit held that a substantial compliance approach was appropriate to determine whether a procedural violation should trigger de novo review. *Id.* at 634. *Gilbertson* thus stated that inconsequential violations of procedural requirements would not entitle the claimant to de novo review where the plan and the claimant are engaged in "an ongoing, good faith exchange of information." *Id.* at 635. The facts of *Gilbertson* are quite different from the facts presented here, however. In *Gilbertson*, the claim was denied for failure to submit certain kinds of evidence. The claimant then submitted evidence addressing those objections, but the plan administrator "never issued a reasoned evaluation of the new evidence," and never contacted the claimant again, even after the claimant asked for a response. *Id.* at 634. Because of the complete lack of meaningful dialogue and the lack of a reasoned decision on the new evidence, the court concluded that de novo review should have been applied. *Id.* at 636-37.

The facts presented here are very different. Contrary to the majority's characterization of the facts, VPA and Jebian

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[5] Moreover, no other circuit has treated a procedural violation *simpliciter* as triggering de novo review.

were, in the words of the district court, engaged in "meaningful dialogue" regarding Jebian's appeal. VPA received Jebian's letter appealing the denial of benefits on November 16, 1998. VPA sent a letter to Jebian on March 15, 1999, explaining in detail the reasons for its denial and asking for further information on two of Jebian's claims. The majority makes much of the fact that this letter was written on the 119th day. Regardless of when the letter was sent, VPA was engaged in a good faith exchange of information with Jebian. On June 11, 1999, VPA informed Jebian that it still had not received all the medical records it had requested and that Jebian apparently had not signed the medical authorization forms they needed. VPA assumed that the claims would remain pending until it received the records. Jebian, however, responded by filing this action. The facts indicate, therefore, that VPA was attempting to engage in a meaningful exchange of information with Jebian but Jebian's response was to file this suit. Unlike *Gilbertson*, de novo review is not appropriate.

Besides being bad law, the majority's position is also bad policy. The district court rejected Jebian's argument for de novo review, noting that Jebian had "shirk[ed] his responsibility under the Plan" to provide VPA with the medical records VPA requested in order to render its decision. In cases such as this one, where the delay is caused by the claimant's failure to furnish the plan administrator with the needed medical records, the majority's decision will force plan administrators to deny such claims within the permitted period, rather than to risk awaiting receipt of the required medical records so that a more reasoned decision, one based on a review of the full medical records, can be made. *Cf. id.* (stating that a "hair-trigger rule" requiring de novo review of every case that involves a procedural violation "could inhibit collection of useful evidence and create perverse incentives for the parties").

There is no indication in the record that Jebian argued below, nor does he argue on appeal, that "the untimely notice so infected the decision making process as to render the

decision to deny suspect." *Tillery*, 280 F.3d at 1199. Thus, nothing in the record, and certainly not the case law, supports applying a de novo standard of review in this case. For these reasons, I respectfully dissent.

APPENDIX B

THIS CONSTITUTES NOTICE OF ENTRY
AS REQUIRED BY FRCP, RULE 77(d)

___ Priority
_X_ Send
___ Cisd
_X_ Enter
_X_ JS-5/JS-6
___ JS-2/J-3

[Filed Oct. 31, 2000
Entered Nov. 1, 2000]

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

DONALD JEBIAN, Plaintiff, v. HEWLETT-PACKARD COMPANY EMPLOYEE BENEFITS ORGANIZATION INCOME PROTECTION PLAN, Defendant.	)	CV 99-9548 (Ex) RSWL **ORDER GRANTING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT** _X_ Docketed _X_ Copies/NTC Sent _X_ JS-5/JS-6 ___ JS-2/JS-3 ___ CLSD

Presently before this Court is Defendant's Motion for Summary Judgment. This Motion was originally set for hearing on August 21, 2000. The Motion was removed from the Court's law and motion calendar pursuant to Federal Rule of Civil Procedure 78 for disposition based on the papers filed.

Having read and carefully considered the papers filed in support of and in opposition to this Motion, as well as Plaintiff's Complaint and the applicable law, the Court finds that there are no genuine issues of material fact and that Defendant is entitled to judgment as a matter of law. Accordingly, the Court **GRANTS** Defendant's Motion for Summary Judgment.

II. BACKGROUND

Plaintiff Donald Jebian began working for Hewlett-Packard ("HP") in 1983 as a computer programmer. HP adopted an employee benefits plan to provide its employees with income in the event of certain disabilities (the "Plan"). Plaintiff was an eligible participant in the Plan in June 1997, when he applied for short-term disability leave. In February 1998, Plaintiff filed a claim for long-term disability benefits under the Plan. The Plan denied Plaintiff's claim and on September 20, 1999, Plaintiff filed the instant suit.

The Plan is self-funded by HP and administered by an independent claims administrator, Voluntary Plan Administrator, Inc. ("VPA"). In order for VPA to approve a claim for benefits under the Plan, a member must establish that he or she is "totally disabled," as defined under the Plan. The Plan provides two definitions of "totally disabled," based on whether the claim is for short-term benefits or long-term benefits. A member applying for short-term disability benefits must show that "following the onset of the injury or sickness, the Member is continuously unable to perform each and every duty of his or her Usual Occupation." The Plan defines "usual occupation" as the normal work assigned to the member by HP. Once the member makes this showing, he or she is entitled to up to thirty-nine weeks of short-term disability benefits.

A member applying for long-term benefits must show that after the thirty-ninth week of receiving short-term benefits, "the Member is continuously unable to perform any occupation for which he or she is or may become qualified by reason of his or her education, training or experience." The

Plan grants VPA discretionary power to determine eligibility for benefits, to determine total disability on the basis of "objective medical evidence," to construe the terms of the Plan, and to make the decision on a review of denied claims. Under the Plan, a member will not be considered totally disabled unless he or she is under the care of and regularly examined by a licensed physician.

When a member makes a claim for benefits, it is the member's sole responsibility to provide VPA with information or evidence in support of his or her claim. VPA must notify the claimant of the denial no later than ninety days after receiving the claim, or no later than 180 days if VPA notifies the claimant that special circumstances require additional processing time. If VPA does not notify the claimant within the specified time, the claim is deemed to have been denied and the claimant may appeal the denial.

On appeal, the claimant continues to be solely responsible for submitting information or evidence on which the claimant intends VPA to consider in rendering a decision on review of the denial. VPA has sixty days from the claimant's request for review in which to notify the claimant of the decision on appeal, and 120 days if VPA notifies claimant that special circumstances require additional processing time. If VPA does not notify claimant within the relevant period of time, the claim is deemed to have been denied on review.

Plaintiff applied for short-term disability leave on June 2, 1997, and on June 3, 1997, Plaintiff was deemed qualified for short-term disability benefits under the Plan. Thirty-nine weeks later, on March 3, 1998, Plaintiff's short-term leave expired. Prior to this date, on February 6, 1998, Plaintiff filed a claim for long-term disability leave.

As part of its evaluation of Plaintiff's claim, VPA requested HealthSouth Rehabilitation Center ("HealthSouth") to conduct various tests to determine Plaintiff's ability, if any, to perform work-related tasks. HealthSouth conducted the requested tests and determined that Plaintiff demonstrated tolerance for "sitting, walking, trunk bending, overhead

reaching, squatting, crouching, kneeling, pushing, and pulling on an occasional basis, and standing, stooping, sustained forward reaching, repetitive forward reaching, pivot twisting/trunk twisting, keying, fine motor skills on a frequent basis."

VPA then hired Rehab West, a vocational specialist, to further assess Plaintiff's physical condition and determine which, if any, occupations Plaintiff was or could become qualified to perform. Rehab west concluded that Plaintiff was not totally disabled because he could perform four occupations that are within his physical capabilities and his educational and vocational background.[1]

On August 3, 1998, VPA provided written notice to Plaintiff of VPA's denial of his claim for long-term disability benefits. The notice acknowledged that Plaintiff's physician, Dr. Lu, provided records of Plaintiff's back problem, but these records stated that Dr. Lu last examined Plaintiff on June 25, 1997, long before Plaintiff's 39-week short-term disability leave would expire, and over seven months before Plaintiff filed a claim for long-term disability benefits. VPA further stated in the notice that its denial of Plaintiff's claim was based on the reports of HealthSouth and Rehab West, both of which concluded that Plaintiff was not "totally disabled" as defined by the Plan. The denial letter also informed Plaintiff of his right to appeal and the process by which to appeal.

On August 18, 1998, Plaintiff informed VPA in writing of his intent to appeal. Later, on October 14, 1998, Plaintiff submitted to VPA a report from Dr. James Landes. Dr. Landes stated in his report that Plaintiff is incapable of performing his job as a computer programmer at HP and is incapable of performing the four alternate jobs that Rehab West

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[1] The four occupations were "user support analyst; data processing auditor; sales representative, computers and EDP systems; and technical training instructor."

claimed he is capable of performing. Dr. Landes formed his opinion based on his review of Plaintiff's claim file and medical records. Dr. Landes did not perform his own diagnosis.

In a letter to VPA, Plaintiff appealed VPA's denial of his claim for long-term disability benefits on November 11, 1998. Plaintiff based his appeal on four arguments: (1) that VPA improperly limited its review to those medical records that originated after the claim date and failed to consider his medical records dating back to 1995; (2) that VPA misread the medical records; (3) that Plaintiff is unable to perform the four alternative jobs cited by Rehab West because those jobs require extensive sitting, standing, or keyboarding; and (4) that the Social Security Administration had approved his claim for Social Security Disability benefits.

VPA responded to Plaintiff's appeal on March 15, 1999. VPA informed Plaintiff that it was reviewing his appeal and that it needed additional medical documentation in order to reach a decision on review. VPA requested Plaintiff's medical records directly from several of his doctors and asked Plaintiff for contact information for two of his doctors. VPA also countered Plaintiff's bases for his appeal, stating that his medical records dating back to April 1995 were irrelevant to determine whether he was "totally disabled" as of March 3, 1998, the effective date of any long-term disability. VPA also stated that the Social Security Administrator's test for total disability differs from that used by VPA.

Two days later, Plaintiff returned a signed authorization of release of information to VPA. On June 11, 1999, VPA advised Plaintiff in writing of the status of his appeal. It stated that it was still awaiting receipt of medical records from four doctors. VPA had sent Plaintiff an authorization form for these doctors but had not received it back. VPA informed Plaintiff that his claim would be pending while VPA waited for these records. Plaintiff never sent these authorization forms to VPA and his case was considered pending until September 20, 1999, the date on which Plaintiff commenced the instant action.

On November 5, 1999, VPA informed Plaintiff in writing that it had officially denied Plaintiff's appeal. The letter provided a detailed explanation for the appeal. The letter reiterated that Plaintiff's medical reports dating back to 1995 were immaterial to his claim that he was totally disabled and entitled to long-term disability benefits as of March 3, 1998. The letter also stated that a review of his medical records on file indicated that Plaintiff did not see any doctor for any disabling condition around the thirty-ninth week of disability, the time at which eligibility for long-term disability benefits would have commenced. Furthermore, the records did not reveal a frequency of treatment for his condition consistent with a disabling condition. Finally, the letter noted that the report of Dr. Landes—which Plaintiff had submitted to VPA on October 14, 1998, in support of his appeal—did not provide any objective evaluation or other medical evidence of Plaintiff's functionality and did not support Plaintiff's claim of total disability.

III. DISCUSSION

A. Legal Standard: Summary Judgment

Summary judgment is appropriate when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56. Where the moving party does not have the burden of proof at trial on a dispositive issue, the moving party may meet its burden for summary judgment by showing an "absence of evidence" to support the non-moving party's case. *Celotex v. Catrett*, 477 U.S. 317, 325 (1986).

The nonmoving party, on the other hand, is required by Rule 56(e) of the Federal Rules of Civil Procedure to go beyond the pleadings and designate specific facts showing that there is a genuine issue for trial. *Id.* at 324. The nonmoving party can meet this requirement by presenting affidavits, depositions, answers to interrogatories, or admissions on file. *Id.* Conclusory allegations unsupported by factual allegations, however, are insufficient to create a triable issue of fact so as to preclude summary judgment. *Hansen v. United*

States, 7 F.3d 137, 138 (9th Cir. 1993) (citing *Marks v. Department of Justice*, 578 F.2d 261, 263 (9th Cir. 1978)).

B. Standard of Review

The parties dispute the appropriate standard by which this Court should review VPA's denial of benefits. Defendant argues that the court must give VPA's decision deference under the "arbitrary and capricious" standard. Plaintiff advocates that the Court should apply a de novo standard of review because VPA's denial of Plaintiff's claim for long-term benefits was based on the passage of time. In such situations, the correct standard of review is de novo, rather than arbitrary and capricious.

Plaintiff has already presented this argument to the Court when Plaintiff filed his Motion for Summary Judgment and the Court rejected it, finding the applicable standard of review in this case to be that which Defendant proposes—the "arbitrary and capricious" standard. The court is bound by its prior finding; therefore, the Court again rejects Plaintiff's argument for de novo review. Under *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the default standard of review is de novo. The administrator must show that the plan gives it discretionary authority in order to get any judicial deference to its decision. *Id.* at 115. Thus, where an ERISA plan vests such discretion in a claims administrator, the more deferential "arbitrary and capricious" standard of review is justified. As the Court reasoned in its prior ruling, the claims administrator for the Plan, VPA, had discretionary authority to determine members' eligibility for benefits under the Plan. Thus, the "arbitrary and capricious" standard applies to the instant case.[2]

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[2] Plaintiff argues in his opposition that VPA failed to decide Plaintiff's appeal in a timely manner, which resulted in an automatic denial of Plaintiff's appeal. This automatic denial, Plaintiff argues, divested VPA of any discretion in deciding the appeal and now warrants de novo review. This Court does not find Plaintiff's argument any more meritorious than

[Footnote continued on next page]

C Evidentiary Objections

1. Declaration of Traci Lachman

Plaintiff objects to the declaration of Traci Lachman[3] except in so far as it authenticates the administrative record. Defendant originally submitted this declaration in support of its Opposition to Plaintiff's Motion for Summary Judgment, which the Court denied on June 19, 2000. Defendant now resubmits that declaration in support of the instant Motion. Attached as Exhibit C to the previously-submitted declaration is the administrative record for Plaintiff's claim. Plaintiff objects to the declaration submitted with this Motion on the ground that it was not part of the administrative record, and if, as Defendant urges, the proper standard of review is the "arbitrary and capricious" standard, then any evidence outside the administrative record is inadmissible to fill in gaps or inconsistencies in the record.

Plaintiff correctly notes that the only evidence that a trial court may consider when reviewing an ERISA plan adminis-

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[Footnote continued from previous page]
it did when Plaintiff originally presented it to the Court in support of his Motion for Summary Judgment. VPA addressed the merit of each of Plaintiff's grounds for appeal in VPA's March 15, 1999, letter and indicated that it needed additional medical documentation before it could render a decision on appeal. VPA named the doctors from which it sought further records. VPA again wrote to Plaintiff on June 11, 1999, indicating that it was still awaiting the receipt of a signed authorization from Plaintiff, a prerequisite to the release of the medical records VPA considered necessary in deciding Plaintiff's appeal. As stated in the Plan, it was Plaintiff's sole responsibility to provide VPA with evidence in support of his claim on review. As of March 15, 1999, Plaintiff was on notice as to further documentation that VPA needed in order to render its decision. Plaintiff cannot now claim that VPA failed to engage in a meaningful dialogue with Plaintiff regarding his appeal and shirk his responsibility under the Plan.

[3] Attached as Exhibit A to Defendant's Motion for Summary Judgment.

trator's decision is the evidence that was before the plan administrator at the time it made its final decision. *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1090-91 (9h Cir. 1999). "A district court should not take additional evidence merely because someone at a later time comes up with new evidence . . . ." *Id.* (quoting *Mongeluzo v. Baxter Travenol Disability Benefit Plan*, 46 F.3d 938, 944 (9th Cir. 1995)) (internal quotation marks omitted).

Plaintiff's application of this principle of law, however, is incorrect. Upon review of a denial of benefits under an ERISA plan, a district court may only consider evidence that was before the plan administrator at the time of the denial. By implication, such evidence is medical or vocational evidence that would suggest or negate the existence of disability as defined by the particular plan at issue. The declaration of Traci Lachman is clearly not medical or vocational evidence tending to establish or negate the existence of Plaintiff's alleged disability. Rather, Ms. Lachman is the VPA representative responsible for the final decision in all claims and benefits under the Plan, including Plaintiff's claim. The general rule limiting a trial court's review to the administrative record does not affect this Court's ability to consider the declaration of Ms. Lachman.

2. November 5, 1999, letter from VPA to Plaintiff's counsel

Plaintiff's second and final evidentiary objection is to VPA's November 5, 1999, letter addressed to Plaintiff's counsel denying Plaintiff's appeal. Plaintiff argues that this letter is inadmissible because it "falls outside the administrative record, which closed either on August 18, 1998, when Plaintiff administratively appealed VPA's denial of benefits,[4]

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[4] Plaintiff errs in stating that he appealed the VPA's decision on August 18, 1998. On this date, Plaintiff merely informed VPA of his *intent* to appeal; he did not submit his formal administrative appeal until November 11, 1998.

or on September 20, 1999, when Plaintiff filed the action now before this Court.

For the reasons stated above regarding the Lachman declaration, the Court has not excluded the November 5, 1999, letter from its review of VPA's denial of Plaintiff's claim.

D. Defendant Is Entitled to Summary Judgment

The medical and vocational reports authored by HealthSouth and Rehab West, and the report of Dr. Landes based on his review of the file were the only pieces of evidence before VPA when it denied Plaintiff's claim. The Plan explicitly states that the claimant is solely responsible for providing VPA with evidence and information in support of his claim. The only evidence Plaintiff submitted was the report of Dr. Landes. VPA partially based its denial of Plaintiff's claim on Rehab West's conclusion that Plaintiff was capable of performing work in four different occupations, each of which was determined to be within Plaintiff's physical capacities and vocational and educational background. A plan administrator may rely on the recommendations of a vocational expert in deciding a claim for benefits. *McKenzie v. General Tel. of Cal.*, 41 F.3d 1310 (9th Cir. 1994)

VPA also did not err, or act unreasonably or capriciously in relying on its own vocational experts rather than the report of Plaintiff's doctor. VPA found that Dr. Landes first examined Plaintiff on September 2, 1998; however, the effective date of any long-term disability was March 3, 1998. The Plan requires that in order for a claimant to be eligible to receive long-term disability benefits, the claimant must meet the definition of "total disability" as stated in the Plan as of the day following the expiration of the thirty-nine-week short-term disability leave. In this case, that date was March 3, 1998. Plaintiff presented no evidence showing that he met the definition of total disability as of this date. Rather, Plaintiff presented evidence from a doctor who first examined him six months after March 3, 1998. VPA was therefore entitled to regard Dr. Landes's report as immaterial.

VPA also did not act unreasonably or contrary to law when it deemed the Social Security Administration's determination of "total disability" irrelevant. An ERISA plan administrator need not consider an award of social security benefits when the medical evidence before the administrator does not support a finding of total disability as of the eligibility date. *See Madden v. ITT Long Term Disability Plan for Salaried Employees*, 914 F.2d 1279, 1285-86 (9th Cir. 1990).

IV. CONCLUSION

There is substantial evidence to support VPA's denial of Plaintiff's claim for long-term disability benefits. VPA considered the evidence before it and did not act arbitrarily, capriciously, or, unreasonably in its denial of Plaintiff's claim. Therefore, the Court finds that there are no genuine issues of material fact and Defendant is entitled to judgment as a matter of law. Accordingly, the Court hereby **GRANTS** Defendant's Motion for Summary Judgment. The Court will adopt Defendant's Proposed Findings of Fact and Conclusions of Law, making any revisions it deems necessary.

IT IS SO ORDERED.

/s/
RONALD S.W. LEW
United States District Judge

DATED: October 31, 2000

APPENDIX C

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

DONALD JEBIAN,

Plaintiff-Appellant,

v.

HEWLETT-PACKARD COMPANY EMPLOYEE BENEFITS ORGANIZATION INCOME PROTECTION PLAN; ERISA PLAN,

Defendants-Appellees.

No. 00-56988

D.C. No. CV-99-09548-RSWL
Central District of California, Los Angeles

ORDER WITHDRAWING OPINION AND DENYING PETITION FOR REHEARING AND PETITION FOR REHEARING EN BANC

Filed November 25, 2003

Before Harry Pregerson, A. Wallace Tashima and Marsha Berzon, Circuit Judges.

ORDER

The opinion and dissenting opinion, filed November 19, 2002, published at 310 F.3d 1173, are withdrawn and replaced by the opinion and dissenting opinion filed concurrently with this order. Judge Pregerson and Judge Berzon have voted to deny Appellees' Petition for Rehearing and to reject Appellees' Petition for Rehearing En Banc. Judge Tashima has voted to grant the petitions. The full court has been advised of the petition for rehearing en banc and no judge has requested a vote on whether to rehear the matter en banc. *See* Fed. R. App. P. 35.

The petition for rehearing is DENIED. The petition for rehearing en banc is REJECTED.

APPENDIX D

[Entered Nov. 2, 2000]

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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
WESTERN DIVISION

DONALD JEBIAN,

Plaintiff,

v.

HEWLETT-PACKARD COMPANY EMPLOYEE ORGANIZATION INCOME PROTECTION PLAN, an ERISA PLAN; DOES 1 Through 10 Inclusive,

Defendants-Appellees.

Case No. 99-09548-RSWL

Hon. Ronald Lew

~~[PROPOSED]~~ **JUDGMENT**

Hearing

Date: August 28, 2000

Time: 9:00 a.m.
Place: Courtroom 21

The Defendant Hewlett-Packard Company Employee Benefits Organization Income Protection Plan (the "Plan"), having brought a Motion for Summary Judgment, and the Court having considered the papers filed in support of and in opposition to Defendant's Motion for Summary Judgment and having heard the oral argument of counsel, and there being no material issues of fact remaining, the Court's judgment is entered as follows:

1. As previously stated in the Court's Order Denying Plaintiff's Motion for Summary Judgment entered on July 7, 2000, Plaintiff's claim for benefits under the Plan is governed by the arbitrary and capricious standard of review.

2. The facts and circumstances surrounding Plaintiff's claim for benefits and the denial of that claim by the contract claims administrator for the Plan do not show that the contract claims administrator denied Plaintiff's claim without explanation and without obtaining the relevant information so as to constitute an abuse of discretion within the meaning of *Booten v. Lockheed Medical Benefit Plan*, 110 F.3d 1461 (9th Cir. 1997).

3. A review of the administrative record in this case shows that Defendant's denial of long-term disability benefits to Plaintiff was entirely reasonable and not arbitrary of capricious.

4. Plaintiff is not entitled to recover under his Complaint.

5. Defendant is entitled to judgment in its favor and against Plaintiff.

Based on the foregoing, IT IS HEREBY ORDERED, ADJUDGED AND DECREED that Defendant's Motion for Summary Judgment is GRANTED, and that JUDGMENT IS HEREBY ENTERED IN FAVOR OF DEFENDANT AND AGAINST PLAINTIFF. Defendant shall petition the Clerk for costs, and may make a motion to the Court for reasonable attorneys' fees in accordance with 29 U.S.C. § 1132(g)(1), any other applicable federal law and Local Rule 16.

Dated November 2, 2000

/s/
Hon. Ronald S.W. Lew
United States District
Court Judge

APPENDIX E

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

DONALD JEBIAN, *Plaintiff-Appellant,* v. HEWLETT-PACKARD COMPANY EMPLOYEE BENEFITS ORGANIZATION INCOME PROTECTION PLAN; ERISA PLAN, *Defendants-Appellees.*	No. 00-56988 D.C. No. CV-99-09548-RSWL OPINION

Appeal from the United States District Court
for the Central District of California
Ronald S.W. Lew, District Judge, Presiding

Argued and Submitted
December 3, 2001—Pasadena, California

Filed November 19, 2002

Before: Harry Pregerson, A. Wallace Tashima and Marsha S. Berzon, Circuit Judges.

Opinion by Judge Berzon;
Dissent by Judge Tashima

COUNSEL

Charles J. Fleishman, Beverly Hills, California, for the appellant.

Joseph P. Busch, III, Gibson, Dunn & Crutcher, Los Angeles, California, for the appellee.

OPINION

BERZON, Circuit Judge:

Background

Donald Jebian, now 63, worked as a software engineer for Hewlett Packard continuously from 1983 to May 1995. In 1990 he began to suffer from a series of orthopedic impairments that caused him pain and made it difficult for him to move normally.

Jebian first developed bilateral shoulder pain. It turned out that he had a massive rotator cuff defect in his right shoulder, which was not diagnosed until 1995. In 1992, Jebian also began to experience back pain. Doctors determined that the cause was lumbar spinal stenosis.[1] His doctors agree that his stenosis is congenital rather than the result of injury. Later, Jebian was diagnosed with lumbar degenerative disc disease, which exacerbated his back pain.

Jebian stopped work in May 1994 because of intractable back pain. He had a lumbar discectomy in June 1995, the first of several surgeries. Because his back pain persisted after the surgery, he had a second surgery on his back in the fall of 1995. Dr. Stark, who examined Jebian at Hewlett Packard's request with regard to a worker's compensation claim in October 1995, predicted that Jebian would

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[1] Spinal stenosis is a narrowing of the lumbar or cervical spinal canal that causes compression of nerve roots and resulting back pain.

need yet another surgery on his back. Jebian also underwent two surgeries on his shoulders in 1996, one on each.

Jebian was a participant in an employee benefit plan ("the Plan") covered by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et. seq.* The Plan, self-funded by Hewlett Packard and administered by an independent claims administrator, Voluntary Plan Administrator ("VPA"), offers both short-term and long-term disability leave. Short-term disability benefits last up to 39 weeks. An applicant for short-term disability benefits must show that "following the onset of the injury or sickness, the Member is continuously unable to perform each and every duty of his or her Occupation."

After 39 weeks, an employee still unable to work must apply separately for long-term disability benefits. Long-term benefits are granted under the Plan if "the Member is continuously unable to perform any occupation for which he or she is or may become qualified by reason of his or her education, training or experience" (emphasis added). The Plan stipulates that disability determinations for either long- or short-term benefits are to be "made by the Claims Administrator on the basis of objective medical evidence."

After first leaving work in May 1995 Jebian applied for and received short-term disability benefits. He applied for long-term benefits after the requisite 39 weeks of short-term benefits. VPA initially denied the application, but on appeal reversed its decision. By the time of that reversal, Jebian had returned to work, so long-term benefits were granted retroactively only for the six-week period before Jebian returned to work.

Jebian shortly left work once again due to the same medical conditions. He tried to return to work in May 1997, but within a matter of weeks he left work for a third time, this time not to return.

VPA found Jebian eligible for short-term disability benefits when he left work in June 1997. In February 1998, with the 39th week of his short-term benefits approaching,

Jebian again applied for long-term benefits. VPA denied Jebian's application for long-term disability benefits on August 3, 1998.

VPA's letter of denial based its decision on two reports that it had commissioned concerning Jebian's condition: a "Work Capacities Assessment" conducted by physical therapists employed by HealthSouth, a company that conducts such physical assessments for insurers and employers, and an "Employability Assessment Report" conducted by a vocational consultant employed by Rehab West, a company that provides vocational assessments.

VPA's denial letter relied largely on HealthSouth's representation that Jebian could tolerate "sitting, walking, trunk bending, overhead reaching, squatting," and other functions, though the HealthSouth report had noted that Jebian had substantive limitations in his ability to carry out these functions. The letter also cited and adopted Rehab West's conclusion that Jebian was professionally and physically qualified to perform four occupations—user support analyst, data processing auditor, sales representative for computers and electronic data processing systems, and technical training instructor. The 1998 Rehab West report was identical to one that had formed the basis for the decision to deny Jebian long-term disability benefits two years earlier (a decision that, as noted, was retracted by VPA on appeal). Rehab West did not conduct its own medical exam of Jebian. Rather, the Rehab West report concluded, in one sentence, that "[i]t also appears that these occupations are within his physical capabilities as per the medical reports provided." It is not clear from the record which medical documents were provided to Rehab West. Precisely the same sentence regarding medical reports had appeared in the 1996 Rehab West report, although Jebian's medical circumstances had

changed greatly by 1998.[2] Further, the Rehab West report does not indicate that any of the jobs it suggests could be done by a person who can sit or stand only for limited time periods.[3]

In November 1998, Jebian appealed the denial of benefits. He argued that crucial records were not considered, that some medical records were misread, and that the alternative employment recommendations were based on erroneous readings of the medical information. Enclosed with his appeal was a letter from Dr. James Landes. Dr. Landes, who had examined Jebian in September 1998, reviewed medical records, the HealthSouth and Rehab West reports, and the denial letter; emphasized that Jebian is incapable of prolonged sitting or standing; and pointed out that the four jobs recommended by Rehab West all involve one or the other. Dr. Landes urged VPA to reconsider its decision.

Under the Plan's language, Jebian's "claim shall be deemed to have been denied on review" if VPA neither responds within 60 days nor informs the claimant that it could take up to 60 days longer to respond. On March 15, 1999, 119 days after receiving Jebian's appeal, VPA wrote to Jebian, responding to his objections but leaving the appeal pending to consider further medical documentation. VPA wrote to Jebian again in June 1999, stating that it was still awaiting some medical records and that the appeal therefore remained pending.

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[2] In particular, Jebian had undergone two additional surgeries in the meanwhile.

[3] Among the occupations suggested is "data processing auditor," a job that by Rehab West's account requires frequent computer use to analyze data and write reports. There is no indication in Rehab West's report that it took into account, regarding this suggested occupation or any of the others, the impact of Jebian's limitations on prolonged sitting.

On September 29, 1999, Jebian filed his complaint in district court. Only after that, on November 5, 1999, did VPA send Jebian a letter finally denying his claim for long-term disability benefits.

The district court reviewed VPA's decision for abuse of discretion and granted summary judgment to the Plan. We reverse. We conclude that the proper standard of review of VPA's decision in this case is de novo. Since the district court's decision, the Ninth Circuit has ruled that the treating physician rule applies to ERISA plan decisions. *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130, 1139 (9th Cir. 2001). We remand in light of both our conclusion concerning the appropriate standard of review and our decision in *Regula*.

DISCUSSION

I

A challenge to an ERISA plan's denial of benefits is reviewed *de novo* "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). If a plan does grant such discretion, a reviewing court applies an "abuse of discretion" or what amounts to the same thing—an "arbitrary and capricious" standard. *See Taft v. Equitable Life Assurance Soc'y*, 9 F.3d 1469, 1471 n.2 (9th Cir. 1994).

The plan before us explicitly grants discretion to decide appeals from denials of claims for benefits to the plan administrator. The pertinent language reads: "The Claims Administrator shall have the discretionary authority to construe the language of the plan and make the decision on review on behalf of the Organization."

The question before us, of first impression in this circuit, is whether a plan administrator's decision, otherwise within the administrator's discretion, can be accorded judicial deference when the purported final, discretionary decision is not

made until after the claim is, according to both the terms of the plan and Department of Labor (DOL) regulations, already automatically deemed denied on review. We conclude that where, according to plan and regulatory language, a claim is "deemed . . . denied" on review after the expiration of a given time period, there is no opportunity for the exercise of discretion and the denial is reviewed *de novo*.

Jebian's letter appealing the denial of benefits is dated November 11, 1998 and was received by VPA on November 16, 1998. VPA did not respond until March 15, 1999.[4] VPA's decision after that lapse in time was in violation of both the Department of Labor's (DOL) ERISA regulations and Plan language. Both the plan and a DOL regulation, 29 C.F.R. § 2560.503-1(h)(1)(i) (1998),[5] required some written notice in response to an appeal within 60 days—even if only to establish an extension. Any appeal not responded to within the requisite time limit was deemed denied. The Plan stated:

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[4] Contrary to the dissent's suggestion (*post* at 28-29), Jebian did not prior to March 15, 1999 refuse to provide any requested medical records. The records were not *requested* until March 15, 1999, one day before the second extended sixty-day period for deciding the appeal ran out. There was plenty of time for VPA to have made the request, and for Jebian to have replied, before the second—let alone the first—sixty-day period expired.

[5] We refer to the Code of Federal Regulations as of 1998, the year Jebian's claim was filed. The pertinent regulation, 29 C.F.R. § 2560, first promulgated in 1977, was amended in 2000. *See* Pension and Welfare Benefits Administration, 65 Fed. Reg. 70,246 (Nov. 21, 2000). The alterations apply to claims filed on or after January 1, 2002. 29 C.F.R. § 2560.503-1(o) (2002). The new regulation shortens from 60 days to 45 the time allowed for initial responses to appeals from denials of disability benefits. 29 C.F.R. § 2560.503-1(i)(3)(i) (2002). Excised from the new regulation is the provision that transgressions of time limitations will result in the claim being "deemed denied." *See* 29 C.F.R. § 2560.503-1(h) (2002).

> If a claimant has not received written notice that additional time is required for review within sixty (60) days of the date his or her request for review is received by the Claims Administrator, the claim shall be deemed to have been denied on review.

See also 29 C.F.R. § 2560.503-1(h)(4) (1998) (similarly providing that appeals neither timely decided nor extended were deemed denied).

The regulation and the Plan further required in all instances a *final* determination within 120 days (60 days plus the 60-day allowable extension) of the appeal. Again, the regulation and the Plan deemed any claim denied unless there was a final determination within that time limit. The Plan stated:

> If a claimant receives proper and timely notice that additional time is required for review, but does not receive written notice of the Claims Administrator's decision with respect to his or her claim within one hundred twenty (120) days after the date the Claims Administrator receives the request for review, the claim shall be deemed to have been denied on review.

See also 29 C.F.R. § 2560.503-1(h)(4) (1998) (similarly providing that claims neither timely decided nor extended on review were deemed denied).

VPA's March 15 letter was written a day before the 120-day limit. The letter responded to Jebian's objections but left the case open to consider further medical documentation. Thus, even if we ignore the initial failure to respond, according to the regulation and the Plan's terms Jebian's claim, the appeal of which was not decided within 120 days, was deemed denied on March 16.

VPA asks us, in effect, to ignore the "deemed . . . denied" language in the regulation and the Plan and to treat its March 15 letter as a good faith component of the "meaningful dialogue between ERISA plan administrators and their beneficiaries," *Booton v. Lockheed Med. Benefit Plan*, 110

F.3d 1461, 1463 (9th Cir. 1997), reinstating the Plan's discretion to determine the claim. We decline to do so.

Firestone directed us to abide by the principle from trust law that "a court of equity will not interfere to control" trustees "in the exercise of a *discretion vested in them by the instrument* under which they act." *Firestone*, 489 U.S. at 111 (internal quotation marks and citation omitted) (emphasis in original). The instrument in this case does vest discretion, but the same instrument and the regulation that governed it set time boundaries within which that discretion must be exercised. We are just as bound by the Plan language deeming denial in the event that time limits are exceeded as we are bound by the Plan language that grants discretion to the Plan administrator. Decisions made outside the boundaries of conferred discretion are not exercises of discretion, the substance of the decisions notwithstanding. If we were to accept VPA's suggestion, use of the *language* of discretion—that is, providing reasons and asking for more information—would become a talisman by which administrators could ensure deference even when they are expressly precluded by the trust agreement from exercising discretion because the time for doing so has passed. To avoid creating such a talisman, we treat Jebian's appeal as having been "deemed . . . denied" pursuant to the Plan's plain terms, and review the denial of the claim *de novo* as one involving no exercise of discretion.[6]

Our holding is consistent with the rule in at least three other circuits on an analogous issue. Those circuits considered whether deference is owed to a decision to revoke bene-

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[6] Analogously, this court has recently interpreted a statute that imposes a deadline for United States Fish and Wildlife Service action as precluding the agency from gaining additional time to make discretionary findings. *See Biodiversity Legal Found. v. Badgley*, 62002 WL 31444519, at *9 (9th Cir. Nov. 4, 2002) ("The exercise of discretion is foreclosed when statutorily imposed deadlines are not met.").

fits when that decision is made by a body other than the one authorized by the procedures set forth in a benefits plan. *Sanford v. Harvard Indus.*, 262 F.3d 590, 597 (6th Cir. 2001); *Sharkey v. Ultramar Energy*, 70 F.3d 226, 229 (2d Cir. 1995); *Rodriguez-Abreu v. Chase Manhattan Bank*, 986 F.2d 580, 584 (1st Cir. 1993). All three circuits concluded that no deference is owed under these circumstances.

The principle underlying these wrong decision-maker cases is that although *Firestone* directs courts to defer to the decisions of plans in which their language grants discretionary authority, that deference applies only when the decision is made by the body vested with discretion. "When an unauthorized body that does not have fiduciary discretion to determine benefits eligibility renders such a decision deferential review is not warranted." *Sanford*, 262 F.3d at 597. Similarly, here we will not defer when a decision is, under the Plan, necessarily the mechanical result of a time expiration rather than an exercise of discretion.[7]

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[7] This precise question has not had extensive treatment in other circuits, and conclusions vary. In *Gritzer v. CBS, Inc.*, 275 F.3d 291, 296 (3d Cir. 2002), the Third Circuit applied *de novo* review to a plan that otherwise granted discretion to the administration because under the plan the employee pension claim was deemed denied. Turning to the analogy between ERISA plans and trusts, the Third Circuit stated: "Where a trustee fails to act or to exercise his or her discretion, *de novo* review is appropriate because the trustee has forfeited the privilege to apply his or her discretion; it is the trustee's analysis, not his or her right to use discretion or a mere arbitrary denial, to which a court should defer." *Id.* (citation omitted). *Gritzer* was a slightly different case from ours, however, because there the plan did not respond at all, either early or late, to the employees' claims.

The Fifth Circuit stated without discussion in *Southern Farm Bureau Life Ins. Co. v. Moore*, 993 F.2d 98, 101 (5th Cir. 1993), that "[i]n our view, the standard of review is no different whether the claim is actually denied or is deemed denied."

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We note that this principle may apply more generally to decisions made in violation of procedures prescribed by applicable regulations or the plan itself. *Sanford* explained that "[t]he logic behind [the cases denying deference to plan decisions made by a body other than the one granted discretion] is that deferential review under the 'arbitrary and capricious' standard is merited for decisions regarding benefits *when they are made in compliance with plan procedures*" (emphasis added). 262 F.3d at 597. When decisions are not in compliance with regulatory and plan procedures, deference may not be warranted.

It is already clear that procedural violations can affect the merits determination concerning whether an abuse of discretion has taken place. *Blau v. Del Monte Corp.*, 748 F.2d 1348 (9th Cir. 1984) (*abrogation on other grounds recognized by Dytrt v. Mountain State Tel. & Tel. Co.*, 921 F.2d 889, 894 n.4 (9th Cir. 1990)), ruled that "[o]rdinarily, a claimant who suffers because of a fiduciary's failure to com-

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In *Daniel v. Eaton Corp.*, 839 F.2d 263, 267 (6th Cir. 1988), which was decided before *Firestone*, the Sixth Circuit stated that "the standard of review is no different whether the appeal is actually denied or is deemed denied." More recently, the Sixth Circuit, while noting *Daniel*, commented that "there is undeniable logic in the view that a plan administrator should forfeit deferential review by failing to exercise its discretion in a timely manner." *Universal Hosps. of Cleveland v. Emerson Elec. Co.*, 202 F.3d 839, 846 n.3 (2000). *Universal Hospitals* left open the standard of review question, as it did not matter to the result. *Id.*

Finally, in *McGarrah v. Hartford Life Ins. Co.*, 234 F.3d 1026 (8th Cir. 2000), the Eighth Circuit refused to consider the failure to respond to an appeal as affecting the standard of review. There is nothing in *McGarrah*, however, indicating that the plan in question contained the "deemed . . . denied" language at issue here. Further, here, the Plan administrator did purport to decide the appeal, albeit late, and is asking us to defer to its decision on review rather than to its original denial of benefits (which did not, of course, consider Jebian's submissions on appeal).

ply with ERISA's procedural requirements is entitled to no substantive remedy," but that if procedural violations result in "substantive harm," then "a court must consider [such violations] in determining whether the decision to deny benefits in a particular case was arbitrary and capricious." *Blau*, 748 F.2d at 1353-54. *Blau* left open the question whether procedural violations influence the standard of review. 748 F.2d at 1353. Moreover, *Blau* was decided before *Firestone*, when our default standard for reviewing ERISA plan decisions was "arbitrary and capricious" rather than *de novo*. For present purposes, we leave the more general issue open and decide only that where the plan itself provides that a particular procedural violation results in an automatic decision rather than one calling for the exercise of the administrator's discretion, that provision is as enforceable as the provision giving the administrator discretionary authority under other circumstances. Deemed denials are not exercises of discretion. They are therefore undeserving of deference under *Firestone* and a *de novo* standard of review applies.[8]

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[8] As should be apparent from the discussion in the text, the dissent's analysis of the standard of review is incorrect for two reasons.

First, the dissent entirely ignores the fact that the limitation on the exercise of discretion upon which we rely *is expressly contained in the plan itself*. Thus, the question is not whether "VPA relinquished the discretion granted in the plan" by failing to respond to the appeal in a timely manner (*post* at 25), but whether VPA is entitled to be regarded as having exercised discretion in deciding the appeal even though *the Plan itself* withdraws that discretion to decide and substitutes an automatic, unreasoned decision when the deadline is not met.

Second, the question here is not whether Jebian is entitled to a "substantive remedy," *Blau*, 748 F.2d at 1353, for the failure to decide the appeal in accord with ERISA. We do not decide that Jebian is to be awarded benefits, damages, or any other relief because VPA violated ERISA. Instead, we simply enforce *the Plan's own terms* regarding whether VPA retained discretionary authority over the appeal once the time limit had lapsed, and apply a *de novo* standard of review to decide

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II

On the merits of the denial of benefits, Jebian points out that VPA never had him examined by, or his medical records reviewed by, a doctor. Neither of the evaluations upon which VPA based its decision was prepared by a doctor. The HealthSouth assessment was conducted by physical therapists. The Rehab West report was prepared by a "vocational consultant."

Rehab West found Jebian to be capable of four occupations. The report first describes those occupations as ones "Jebian can do within his education and vocational background." The report adds: "It also appears that these occupations are within his physical capabilities as per the medical records provided," but, as noted, it is not clear from the record which medical records were reviewed by Rehab West, and Rehab West issued identical reports in 1996 and 1998 despite changes in Jebian's medical circumstances.

Jebian stresses, furthermore, that VPA's decision is in tension with the opinions of several doctors, including the doctors who treated him, all of whom agree that Jebian can neither sit nor stand except for a very short time and is therefore permanently disabled. Dr. James Stark examined Jebian at Hewlett Packard's request with regard to a workers' compensation claim. Dr. Stark wrote in October 1995, after Jebian had undergone his second back surgery, that "Mr. Jebian is not capable of working at this time because of his sitting and standing limitations. It is not clear whether he will ever

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whether Jebian is entitled to benefits. The line of post-*Blau* cases the dissent relies upon, which involved claims that benefits should be due because of procedural violations of the statute or regulations, are therefore inapposite. *See, e.g., Parker v. BankAmerica Corp.*, 50 F.3d 757, 768 (9th Cir. 1995) (rejecting argument that employees should recover benefits because the administration failed to provide them with a copy of the plan on request).

be able to compete in the open labor market because of pain related physical limitations."

Dr. Lu, who has treated Jebian since February 1995, filled out a "Physician's Certification of Disability" for Jebian in September 1997. Dr. Lu noted on that form that Jebian "has tried to RTW [return to work] twice, but was unable to tolerate sitting more than a few minutes at a time, or standing." Dr. Lu filled out another Hewlett Packard Company form on January 30, 1998. This time Dr. Lu checked a box stating that his patient is "now totally disabled from any other work." Dr. Lu checked another box indicating that he did not "expect a fundamental or marked change in the future." Dr. Lu commented on the form that Jebian is subject to a "[s]evere limitation of sitting and standing ([maximum 5 minutes] at a time)" and "has too much pain to sit or stand more than a few minutes at a time."

Dr. Landes, who began treating Jebian in September 1998 after Jebian moved to a new area, stated in his November 1998 letter in support of Jebian's appeal that patients with his condition "are permanently precluded from activities requiring . . . prolonged sitting or prolonged standing," and that "[h]is current physical exam findings confirm the information in the records and support his claim of permanent disability, limiting him to sedentary work." Dr. Landes also reviewed in his letter the particular occupations cited by the Rehab West report, concluding that Jebian could not stand or sit for sufficiently sustained periods to perform the jobs recommended. Even the HealthSouth Report relied upon by VPA, for that matter, seems to indicate that Jebian can only sit for twenty minutes at a time and stand for thirty minutes at a time. Additionally, there was medical corroboration of Jebian's constant pain, in the form of extensive records concerning his participation in a study, supervised by Dr. Lacy, of a new pain medication. To obtain the medication, Jebian was required to keep a diary and visit Dr. Lacy's office frequently, which he did.

VPA chose, despite this evidence, to deny Jebian benefits in accord with the suggestion of the Rehab West report

that there were four occupations in the market that Jebian was capable of performing. The district court found that VPA did not abuse its discretion in doing so. After the district court's decision, the Ninth Circuit ruled in *Regula*, 266 F.3d 1130, that the treating physician rule applies to ERISA plan decisions. According to the rule, an ERISA plan administrator must "give deference to the opinions of the claimant's treating physician, because he is employed to cure and has a greater opportunity to know and observe the patient as an individual." *Id.* at 1139 (internal citation and quotation marks omitted).

Applying the *Regula* rule and the *de novo* standard of review to the district court's grant of summary judgment, we conclude that there is a genuine issue of fact concerning whether Jebian is disabled. *See Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1094 (9th Cir. 1999) (en banc). There is medical evidence in the record from Jebian's treating physicians documenting the physiological basis for his back pain; the aggressive surgical treatment he underwent; the persistence of the pain, necessitating continued treatment with innovative painkillers; and professional assessments that Jebian was functionally precluded from standing or sitting for more than a few minutes at a time.

VPA argues that Jebian's extensive medical evidence does not pertain to the relevant moment, which is the end of the temporary disability benefit period, March 3, 1998. A trier of fact, reviewing the entire record submitted to VPA, could conclude otherwise. For example, although VPA rejected records from 1995 as "immaterial" to Jebian's disability in March 1998, in fact those records are pertinent, although certainly not determinative. They both trace the history of Jebian's back injury and indicate that it is capable of causing total disability. Jebian's treating physician, Dr. Lu, certified on January 30, 1998, that Jebian remained severely functionally limited due to his back injury. Dr. Lu's opinion was based on a June 1997 office visit and over two years' experience in treating Jebian's back ailment. Finally, Dr. Landes, contrary to the district court's understanding,

did examine Jebian himself, in September 1998, and based his October 1998 letter in part on that examination.

A trier of fact, reviewing the evidence before VPA *de novo*, could infer that functional limitations confirmed by treating physicians in June 1997, May 1998, and September 1998, more likely than not existed in March 1998 as well, rather than disappearing before March 1998 and reappearing thereafter. Further, applying the *Regula* treating physician rule, a *de novo* trier of fact could conclude that VPA's explanations of its decision to this point have provided no "specific, legitimate reasons . . . based on substantial evidence in the record," 266 F.3d at 1140 (internal citation and quotation marks omitted), for rejecting this inference based on the treating physicians' reports.

While under an abuse of discretion standard our review is limited to the record before the plan administrator, *McKenzie v. General Tel. Co.*, 41 F.3d 1310, 1316 (9th Cir. 1994), this limitation does not apply to *de novo* review. *Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan*, 46 F.3d 938, 944 (9th Cir. 1995) (on remand, district court has discretion to take additional evidence "when circumstances clearly establish that additional evidence is necessary to conduct an adequate *de novo* review of the benefit decision").[9] Neither Jebian nor the plan

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[9] We take it that the dissent's contrary statement, citing *Kearney*, as well as its derivative conclusion that we should direct that the district court remand the decision to the plan administrator, assume an abuse of discretion standard of review, the central point upon which we disagree. *Mongeluzo* makes quite clear, as does *Kearney*, that where review is *de novo*, the record is not necessarily so limited. *Mongeluzo*, 46 F.3d at 944; *Kearney*, 175 F.3d at 1091-92. Similarly, the holding in *Saffle v. Sierra Pac. Power Co. Bargaining Unit Long Term Disability Income Plan*, 85 F.3d 455 (9th Cir. 1996), regarding the need to remand to the administrator who applied the wrong legal standard is explicitly limited to the abuse of discretion context. *Id.* at 461 (recognizing that *Mongeluzo*, applying a *de novo* standard, remanded to the district court "for a factual determination under a

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has had the opportunity to consider whether, in light of the new *Regula* standard, they wish to submit further evidence for the trial court's consideration. The trial court therefore has not determined whether to admit such additional evidence so as to "enable the full exercise of informed and independent judgment." *Id.* at 943; *see also id.* at 944 (a "change in the posture of the case" can justify taking additional evidence on *de novo* review). We therefore remand to the district court to allow consideration of further developments of the record under the *Mongeluzo* standard and *de novo* review of the denial of the benefits claim.[10]

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proper construction of the terms of the plan," but holding that "remand [to the administrator] for reevaluation of the merits of a claim is the correct course to follow when an ERISA plan administrator, with discretion to apply a plan, has misconstrued the Plan and applied a wrong standard to a benefits determination.").

10 This case, we note, is in a somewhat different posture than *Kearney*, because the district court originally reviewed the existing record on an abuse of discretion rather than a *de novo* basis. Consequently, even if the district court does not admit any further evidence, its role in conducting a bench trial on the entire record compiled by VPA will be entirely different from its previous deferential review. *Compare Kearney*, 175 F.3d at 1095 (opinion of Kleinfeld, J.) (even where district court decided summary judgment motion on the same review standard, it makes sense to remand for a bench trial on the record because "[t]he district judge will be asking a different question" and will have to make factual findings) *with id.* at 1099 (Reinhardt, J., concurring in the result) ("it would make no sense to remand" to review the same record *de novo* on the merits as was reviewed de novo on summary judgment). There is, consequently, no need to decide the question arguably left open in *Kearney* concerning the necessity for a remand under the circumstances of that case. *Compare id.* at 1094-95 (opinion of Kleinfeld, J.) (a majority of the court approved permitting the district court on remand to try the case on the administrative record) *with id.* at 1096 (opinion of B. Fletcher, J.) (characterizing Judge Kleinfeld's opinion as one for a plurality), *and id* at 1097 (opinion of Reinhardt, J.) (agreeing with Judge B. Fletcher's characterization of Judge Kleinfeld's opinion as a plurality opinion, "at least with respect to Parts III & IV").

Conclusion

We reverse the grant of summary judgment to the Plan and remand for proceedings consistent with this opinion.

REVERSED and REMANDED.

TASHIMA, Circuit Judge, dissenting:

I dissent because the majority forfeits an independent ERISA administrator's plan-given authority to exercise its discretion when ruling on a plan member's claim, simply because the administrator was late in ruling on a claim for benefits and, in doing so, creates an inter-circuit conflict. The majority acknowledges that the plan "explicitly grants discretion to decide appeals from denials of claims for benefits to the plan administrator." Maj. op. at 10. Further, the record reveals that the independent plan administrator, Voluntary Plan Administrator ("VPA"), did exercise its discretion in denying Jebian's appeal. To apply the non-deferential, de novo standard of review solely because of a procedural irregularity is an extreme measure warranted neither by the facts of this case nor by the cases on which the majority relies. As I explain below, all of those cases involved circumstances very different from those presented here. On the contrary, the majority's conclusion conflicts with the decisions of the only circuit to have dealt with the precise issue we face, as well as with the reasoning of our own precedent regarding the effect of procedural violations.

Jebian's letter appealing the denial of benefits is dated November 11, 1998, and was received by VPA on November 16, 1998. VPA responded on March 15, 1999, with a letter denying some of Jebian's claims and asking for further information regarding two of his claims. The letter explained in detail the reasons for VPA's decision. This letter was sent after the 60-day period required by 29 C.F.R. § 2560.503-1(h)(4)(i), but before the 120-day limit. On June 11, 1999, VPA wrote to Jebian to inform him that it had received some, but not all, of the medical records it had requested, and that

the medical offices stated that Jebian had not returned the medical authorization forms they needed in order to release the rest of the records. VPA indicated that it would assume the claims were pending until it received the records. Jebian responded by filing this action on September 20, 1999. On November 5, 1999, VPA sent Jebian a letter again explaining the reasons for the denial of benefits and giving further explanations based on the records it had received.

The cases cited by the majority do not support its conclusion to strip the plan administrator of its discretion. For example, in *Rodriguez-Abreu v. Chase Manhattan Bank*, 986 F.2d 580 (1st Cir. 1993), the decision regarding benefits was made by someone who was not authorized by the plan to make that decision. Likewise, in *Sanford v. Harvard Indus., Inc.*, 262 F.3d 590 (6th Cir. 2001), the court affirmed the district court's determination that it was not the authorized party that made the benefits determination, but "the company at a meeting prompted by a union grievance held under the auspices of the [collective bargaining agreement]." *Id.* at 596-97. Thus, in both *Rodriguez-Abreu* and *Sanford*, unlike this case, the decision regarding benefits was made by someone who was not given discretionary authority by the plan. The First and Sixth Circuits therefore properly upheld the district courts' use of the de novo standard of review rather than the abuse of discretion standard. *Id.*; *Rodriguez-Abreu*, 986 F.2d at 584. Finally, in *Sharkey v. Ultramar Energy Ltd.*, 70 F.3d 226, 229-30 (2d Cir. 1995), the court stated that the denial of benefits is reviewed de novo if an unauthorized party makes the determination, but found that there was insufficient evidence of who actually made the determination in order to uphold the grant of summary judgment. It therefore reversed the grant of summary judgment and remanded. *Id.* at 230.

Unlike *Rodriguez-Abreu*, *Sanford*, and *Sharkey*, the instant case does not involve an unauthorized party making the benefits determination. VPA, as the majority concedes, is the party granted the discretionary authority by the plan to decide claim appeals. In cases in which the party that is given discretionary authority by the plan did not actually exercise its

discretion, such as those cited by the majority, it makes sense to apply the de novo standard of review. Here, however, the discretion was exercised by the party in whom it was vested by the plan, VPA, albeit in an untimely manner.[1]

The Eighth Circuit addressed the precise question we face in a case with facts similar to those presented here, *McGarrah v. Hartford Life Ins. Co.*, 234 F.3d 1026 (8th Cir. 2000). In *McGarrah*, the Eighth Circuit rejected the claimant's argument that the insurance company's failure to respond to his appeal from an adverse decision entitled the claimant to a less deferential standard of review. *Id.* at 1030-31. The insurance company in *McGarrah* completely failed to respond to the claimant's appeal. The court acknowledged that the company's failure to respond was "a serious procedural irregularity." *Id.* at 1031 (citing 29 C.F.R. § 2560.503-1(h)(3)). It relied, however, on its decision in *Buttram v. Cent. States, S.E. & S.W. Areas Health & Welfare Fund*, 76 F.3d 896 (8th Cir. 1996), in which it stated that procedural irregularities "must have some connection to the substantive decision reached; i.e., they must cause the actual decision to be a breach of the plan trustee's fiduciary obligations." *Id.* at 901. Reasoning that the insurance company had made a thorough investigation and adequately explained the basis for its decision, the court in *McGarrah* concluded that the claimant failed to meet his burden of presenting evidence that the irregularity raised serious doubts about the integrity of the decision making process. *McGarrah*, 234 F.3d at 1031. The court therefore held that the district court properly applied

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[1] The majority's emphasis on the fact that it was the plan itself that deemed the claim denied, not just the regulations, is irrelevant because the plan merely mirrored the language in the regulation in force at the time, 29 C.F.R. § 2560.503-1(h) (1999). Section 2560.503-1 was amended in 2000, removing the language stating that a claim is deemed denied on review if the claimant does not receive written notice within sixty or 120 days. *See* 65 Fed. Reg. 70246, 70265, 70268-69 (Nov. 21, 2000).

the deferential abuse of discretion standard.[2] *Id.*; *see also Tillery v. Hoffman Enclosures, Inc.*, 280 F.3d 1192, 1198-99 (8th Cir. 2002) (upholding the district court's decision to review the decision for an abuse of discretion where the administrator's "failure to provide [the beneficiaries] with timely notice of the denial and of their appeal rights" resulted in a procedural irregularity, but the irregularity did not "so undermine the decision of the plan administrator as to render it suspect"); *Clapp v. Citibank, N.A. Disability Plan (501)*, 262 F.3d 820, 827-28 (8th Cir. 2001) (stating that a "sliding-scale" standard of review is appropriate only if the claimant presents material, probative evidence demonstrating a palpable conflict of interest or serious procedural irregularity that caused a serious breach of fiduciary duty, and concluding that a less deferential standard of review was not warranted).

Here, VPA's response detailed the reasons for the denial of Jebian's appeal. There is no evidence in the record that VPA relinquished the discretion granted it in the plan

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[2] The majority dismisses *McGarrah* on the basis that "[t]here is nothing in *McGarrah* . . . indicating that the plan in question contained the 'deemed . . . denied' language at issue here." Maj. op. at 14 n.7. The same regulations as were in force in the instant case, containing the "deemed denied" language, were in force at the time of the appeal of benefits in *McGarrah*. Thus, the appeal in *McGarrah* presumably was also deemed denied, at least by operation of the regulations, if not also by the plan itself, a question not addressed by *McGarrah*. Whether it is the regulation or the plan, or both, as in the instant case, that deems the claim denied, is irrelevant. The question is whether the import of the "deemed denied" language is that discretion is completely removed from the administrator, as the majority concludes, or whether the untimeliness is merely a procedural violation. Where, as here, the administrator has exercised its discretion, and the claimant has presented no evidence that the timing of the decision prejudiced him in any way, it does not make sense to strip the administrator of its authority, regardless of whether the "deemed denied" language is contained in the plan or the regulations.

or that the untimeliness of its response raised doubts about the integrity of the decision-making process.[3]

"Ordinarily, a claimant who suffers because of a fiduciary's failure to comply with ERISA's procedural requirements is entitled to no substantive remedy." *Blau v. Del Monte Corp.*, 748 F.2d 1348, 1353 (9th Cir. 1985) (citation omitted); *see also Kent v. United of Omaha Life Ins. Co.*, 96 F.3d 803, 807 (6th Cir. 1996) ("Generally, the courts have recognized in E.R.I.S.A. cases that procedural violations entail substantive remedies only when some useful purpose would be served."). As the majority observes, the question of whether procedural violations influence the standard of review was left open in *Blau*.[4] In *Blau*, "there was no summary plan description, no claims procedure, and no provision to inform participants in writing of anything;" in short, the employer "failed to comply with virtually every applicable mandate of ERISA." 748 F.2d at 1353. We reasoned that the egregious procedural violations "work[ed] a substantive harm" by "alter[ing] the substantive relationship between employer and employee that disclosure, reporting and fiduciary duties sought to balance somewhat more equally." *Id.* at 1354. "Thus, in reviewing an administrator's decision, a court must consider continuing procedural viola-

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[3] Both *McGarrah* and the instant case are distinguishable from *Gritzer v. CBS, Inc.*, 275 F.3d 291 (3d Cir. 2002), cited by the majority, at 13 n.7, because, in *Gritzer*, the plan administrator "never made any effort to analyze" the appellants' initial claim for benefits, "much less to advise them of what that analysis disclosed," until after the litigation was filed. *Id.* at 295.

[4] As the majority notes, *Blau* was decided before *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), when the default standard of review of administrator's decisions under ERISA was the deferential "arbitrary" or "capricious" standard. *Blau*, 748 F.2d at 1353. In the instant case, however, the default standard of review would be the abuse of discretion standard as well, because of the explicit grant of discretionary authority contained in the plan.

tions in determining whether the decision to deny benefits in a particular case was arbitrary and capricious." *Id.*

While *Blau* left the question open, we have since required claimants to show that a violation of ERISA's procedural requirements "'caused a substantive violation or themselves worked a substantive harm.'" *Parker v. BankAmerica Corp.*, 50 F.3d 757, 769 (9th Cir. 1995) (quoting *Bogue v. Ampex Corp.*, 976 F.2d 1319, 1326 n.33 (9th Cir. 1992)); *McKenzie v. Gen. Tel. Co.*, 41 F.3d 1310, 1314-16 (9th Cir. 1994) (reasoning that the insurance company's procedural violation did not prejudice the claimant's "opportunity to obtain a full and fair review of his claim," and consequently affirming the district court's holding that the violation did not cause the claimant substantive harm); *Bogue*, 976 F.2d at 1326 (concluding that the claimant "ha[d] not met his requirement of showing that any procedural defects caused him substantive harm or involved a substantive violation of ERISA"). Thus, even though *Blau* and its progeny deal with whether the claimant was entitled to a substantive remedy, rather than whether a less deferential standard of review should apply, the question we faced in *Blau is* the same as that we face here—that is, what should be the consequence of a procedural violation?

Similar to *Blau*, our sister circuits have adopted a rule of substantial compliance in determining whether violations of 29 C.F.R. § 2560.503-1's claims procedures warrant relief; that is, a decision regarding benefits will not be upset for procedural violations if the company has substantially complied with procedural requirements such that the claimant has "all the necessary information at a time when the participant still has a meaningful opportunity for appeal and for full and fair review." *Schleibaum v. Kmart Corp.*, 153 F.3d 496, 499 (7th Cir. 1998) (citations omitted); *see, e.g.*, *Perrino v. S. Bell Tel. & Tel. Co.*, 209 F.3d 1309, 1318 (11th Cir. 2000) (stating that claimants should not be able to avoid the exhaustion requirement if technical deficiencies in a claims procedure do not hinder effective administrative review of their claims); *Terry v. Bayer Corp.*, 145 F.3d 28, 39 (1st Cir.

1998) (rejecting a claim for relief from an adverse decision regarding benefits where no prejudice resulted from inadequate notice of the denial, stating that "ERISA's notice requirements are not meant to create a system of strict liability for formal notice failures"); *Heller v. Fortis Benefits Ins. Co.*, 142 F.3d 487, 492-93 (D.C. Cir. 1998) (reasoning that, "although the initial letter from [the insurance company] informing [the claimant] of the denial of her disability benefits did not conform to the requirements of the regulations," the communication between the company, the claimant, and her lawyer insured that she understood the reasons for the denial of benefits and her right to appeal the decision); *Kent*, 96 F.3d at 807-08 (adopting the rule that a decision will be upheld even if procedures have been violated, if the claimant is "notified of the reasons for the denial of the claim and [has] a fair opportunity for review"); *Hines v. Mass. Mut. Life Ins. Co.*, 43 F.3d 207, 211 (5th Cir. 1995) (stating that the "[f]ailure to fulfill procedural requirements generally does not give rise to a substantive damage remedy," except "when the violations are continuous and amount to substantive harm," and citing *Blau*); *Sheppard & Enoch Pratt Hosp., Inc. v. Travelers Ins. Co.*, 32 F.3d 120, 127 (4th Cir. 1994) (finding no prejudice in a plan administrator's violations of 29 C.F.R. § 2560.503-1's requirements of a timely and specific response, stating that the notice substantially complied with the regulation); *Donato v. Metro. Life Ins. Co.*, 19 F.3d 375, 382-83 (7th Cir. 1994) (stating that substantial compliance with the regulations is sufficient, and concluding that the claimant had received information sufficient to permit effective review).

Thus, although *Blau* left open the issue of the applicable standard of review when ERISA's procedural requirements have been violated, it also set forth the principle that the claimant must show some type of prejudice or harm that results from a procedural violation of ERISA. We have relied on that principle in affirming benefits decisions, *see, e.g.*, *Parker*, 50 F.3d at 769; *McKenzie*, 41 F.3d at 1315-16, and other circuits have engaged in a similar analysis in determin-

ing the effect of procedural violations of ERISA, as the cases cited above demonstrate.

Our line of cases following *Blau* firmly establishes the law of the circuit that a showing of prejudice from a procedural violation of ERISA, *i.e.*, that the violation caused the claimant substantive harm, is required before relief can be granted based on such a violation. *Parker*, 50 F.3d at 769; *McKenzie*, 41 F.3d at 1314-16; *Bogue*, 976 F.2d at 1326 & n.33. The majority's decision today literally disregards circuit precedent that is clearly relevant to the instant case without so much as even mentioning those cases.[5]

Besides being bad law, the majority's position is also bad policy. The district court rejected Jebian's argument for de novo review, noting that Jebian had "shirk[ed] his responsibility under the Plan" to provide VPA with the medical records VPA requested in order to render its decision. In cases such as this one, where the delay is caused by the claimant's failure to furnish the plan administrator with the needed medical records, the majority's decision will force plan administrators to deny such claims within the permitted period, rather than to risk awaiting receipt of the required medical records so that a more reasoned decision, one based on a review of the full medical records, can be made.

There is no indication in the record that Jebian argued below, nor does he argue on appeal, that "the untimely notice so infected the decision making process as to render the decision to deny suspect." *Tillery*, 280 F.3d at 1199. Thus, nothing in the record, and certainly not the case law, supports applying a de novo standard of review in this case. For these reasons, I respectfully dissent.

As the majority indicates, *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130 (9th

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[5] Moreover, no other circuit has treated a procedural violation *simpliciter* as triggering de novo review.

Cir. 2001), was decided after the district court's decision was rendered. That case imported the "treating physician rule" from the Social Security context to ERISA benefit decisions. While I agree with the majority that this issue should now be considered on remand, I disagree that it is the district court, rather than the plan administrator, that should consider the *Regula* issue in the first instance. The district court's review of ERISA benefit determinations is limited to the record made before the plan administrator. *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1090 (9th Cir. 1999) (en banc). We have also held, in a closely analogous context, that "remand [to the plan administrator] is the correct course to follow when an ERISA plan administrator, with discretion to apply a plan, has misconstrued the Plan and applied a wrong standard to a benefits determination." *Saffle v. Sierra Pac. Power Co. Bargaining Unit Long Term Disability Income Plan*, 85 F.3d 455, 461 (9th Cir. 1996). For these reasons, I would remand the matter to the plan administrator for it to exercise its discretion in the first instance, taking into account the newly-imposed treating physician rule of *Regula*.

Thus, I would remand to the district court for it to determine whether the procedural violation "worked a substantive harm" against Jebian.[6] *Parker*, 50 F.3d at 769 (internal quotation marks omitted). If the district court concludes that it did not, it should remand the matter to the plan administrator for its reevaluation of Jebian's claim in light of *Regula*.

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6 As indicated above, under *Kearney*, the district court's review is limited to the record that was before the plan administrator. On remand, however, "[t]he district judge will be asking a different question as he reads the evidence, not whether there is a genuine issue of material fact" regarding the denial of benefits, *Kearney*, 175 F.3d at 1095, but whether the procedural violation "prejudice[d] [Jebian's] opportunity to obtain a full and fair review of his claim," *McKenzie*, 41 F.3d at 1316.

APPENDIX F

UNITED STATES CODE

TITLE 29—LABOR

CHAPTER 18—EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM

SUBCHAPTER 1—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

SUBTITLE A—GENERAL PROVISIONS

* * * * *

§ 1132. Civil Enforcement

(a) Persons empowered to bring a civil action. A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), (6) of subsection (c) or under subsection (i) or (*l*) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021, of this title or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

APPENDIX G

UNITED STATES CODE

TITLE 29—LABOR

CHAPTER 18—EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM

SUBCHAPTER 1—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

SUBTITLE B—REGULATORY PROVISIONS

* * * * *

§ 1133. Claims Procedure

In accordance with regulations of the Secretary, every employee benefit plan shall—

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

APPENDIX H

[2003 Version]

CODE OF FEDERAL REGULATIONS

TITLE 29—LABOR

CHAPTER XXV—EMPLOYEE BENEFITS SECURITY ADMINISTRATION, DEPARTMENT OF LABOR

PART 2560—RULES AND REGULATIONS FOR ADMINISTRATION AND ENFORCEMENT

§ 2560.503-1. Claims procedure

(a) *Scope and purpose.* In accordance with the authority of sections 503 and 505 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants). Except as otherwise specifically provided in this section, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act.

(b) *Obligation to establish and maintain reasonable claims procedures.* Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). The claims procedures for a plan will be deemed to be reasonable only if—

(1) The claims procedures comply with the requirements of paragraphs (c), (d), (e), (f), (g), (h), (i), and (j) of this section, as appropriate, except to the extent that the claims procedures are deemed to comply with some

or all of such provisions pursuant to paragraph (b)(6) of this section;

(2) A description of all claims procedures (including, in the case of a group health plan within the meaning of paragraph (m)(6) of this section, any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures) and the applicable time frames is included as part of a summary plan description meeting the requirements of 29 CFR 2520.102-3;

(3) The claims procedures do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits. For example, a provision or practice that requires payment of a fee or costs as a condition to making a claim or to appealing an adverse benefit determination would be considered to unduly inhibit the initiation and processing of claims for benefits. Also, the denial of a claim for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize the life or health of the claimant (e.g., in the case of a group health plan, the claimant is unconscious and in need of immediate care at the time medical treatment is required) would constitute a practice that unduly inhibits the initiation and processing of a claim;

(4) The claims procedures do not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an adverse benefit determination. Nevertheless, a plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant, provided that, in the case of a claim involving urgent care, within the meaning of paragraph (m)(1) of

this section, a health care professional, within the meaning of paragraph (m)(7) of this section, with knowledge of a claimant's medical condition shall be permitted to act as the authorized representative of the claimant; and

(5) The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants.

(6) In the case of a plan established and maintained pursuant to a collective bargaining agreement (other than a plan subject to the provisions of section 302(c)(5) of the Labor Management Relations Act, 1947 concerning joint representation on the board of trustees)—

(i) Such plan will be deemed to comply with the provisions of paragraphs (c) through (j) of this section if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference—

(A) Provisions concerning the filing of benefit claims and the initial disposition of benefit claims, and

(B) A grievance and arbitration procedure to which adverse benefit determinations are subject.

(ii) Such plan will be deemed to comply with the provisions of paragraphs (h), (i), and (j) of this section (but will not be deemed to comply with paragraphs (c) through (g) of this section) if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference a grievance and arbitration procedure to which adverse benefit determi-

nations are subject (but not provisions concerning the filing and initial disposition of benefit claims).

(c) *Group health plans.* The claims procedures of a group health plan will be deemed to be reasonable only if, in addition to complying with the requirements of paragraph (b) of this section—

(1)(i) The claims procedures provide that, in the case of a failure by a claimant or an authorized representative of a claimant to follow the plan's procedures for filing a pre-service claim, within the meaning of paragraph (m)(2) of this section, the claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant or authorized representative, as appropriate, as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be oral, unless written notification is requested by the claimant or authorized representative.

(ii) Paragraph (c)(1)(i) of this section shall apply only in the case of a failure that—

(A) Is a communication by a claimant or an authorized representative of a claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and

(B) Is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

(2) The claims procedures do not contain any provision, and are not administered in a way, that requires a claimant to file more than two appeals of an adverse benefit determination prior to bringing a civil action under section 502(a) of the Act;

(3) To the extent that a plan offers voluntary levels of appeal (except to the extent that the plan is required to do so by State law), including voluntary arbitration or any other form of dispute resolution, in addition to those permitted by paragraph (c)(2) of this section, the claims procedures provide that:

(i) The plan waives any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not elect to submit a benefit dispute to any such voluntary level of appeal provided by the plan;

(ii) The plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending;

(iii) The claims procedures provide that a claimant may elect to submit a benefit dispute to such voluntary level of appeal only after exhaustion of the appeals permitted by paragraph (c)(2) of this section;

(iv) The plan provides to any claimant, upon request, sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the decision of a claimant as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the claimant's rights to any other benefits under the plan and information about the applicable rules, the claimant's right to representation, the process for selecting the decisionmaker, and the circumstances, if any, that may affect the impartiality of the decisionmaker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and

(v) No fees or costs are imposed on the claimant as part of the voluntary level of appeal.

(4) The claims procedures do not contain any provision for the mandatory arbitration of adverse benefit determinations, except to the extent that the plan or procedures provide that:

(i) The arbitration is conducted as one of the two appeals described in paragraph (c)(2) of this section and in accordance with the requirements applicable to such appeals; and

(ii) The claimant is not precluded from challenging the decision under section 502(a) of the Act or other applicable law.

(d) *Plans providing disability benefits.* The claims procedures of a plan that provides disability benefits will be deemed to be reasonable only if the claims procedures comply, with respect to claims for disability benefits, with the requirements of paragraphs (b), (c)(2), (c)(3), and (c)(4) of this section.

(e) *Claim for benefits.* For purposes of this section, a claim for benefits is a request for a plan benefit or benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims. In the case of a group health plan, a claim for benefits includes any pre-service claims within the meaning of paragraph (m)(2) of this section and any post-service claims within the meaning of paragraph (m)(3) of this section.

(f) *Timing of notification of benefit determination.* (1) *In general.* Except as provided in paragraphs (f)(2) and (f)(3) of this section, if a claim is wholly or partially denied, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the plan, unless the plan administrator determines that special circumstances require an extension of time for processing the claim. If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of

the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the benefit determination.

(2) *Group health plans.* In the case of a group health plan, the plan administrator shall notify a claimant of the plan's benefit determination in accordance with paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, as appropriate.

(i) *Urgent care claims.* In the case of a claim involving urgent care, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan. In the case of such a failure, the plan administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph (f)(2)(i) shall be made in accordance with paragraph (g) of this section. The plan administrator shall notify the claimant of the plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of—

(A) The plan's receipt of the specified information, or

(B) The end of the period afforded the claimant to provide the specified additional information.

(ii) *Concurrent care decisions.* If a group health plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments—

(A) Any reduction or termination by the plan of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

(B) Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the plan administrator shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with paragraph (g) of this section, and appeal shall be governed by paragraph (i)(2)(i), (i)(2)(ii), or (i)(2)(iii), as appropriate.

(iii) *Other claims.* In the case of a claim not described in paragraphs (f)(2)(i) or (f)(2)(ii) of this

section, the plan administrator shall notify the claimant of the plan's benefit determination in accordance with either paragraph (f)(2)(iii)(A) or (f)(2)(iii)(B) of this section, as appropriate.

(A) *Pre-service claims.* In the case of a pre-service claim, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the plan. This period may be extended one time by the plan for up to 15 days, provided that ~~the~~ plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph (f)(2)(iii)(A) shall be made in accordance with paragraph (g) of this section.

(B) *Post-service claims.* In the case of a post-service claim, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that

the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(3) *Disability claims*. In the case of a claim for disability benefits, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the plan. This period may be extended by the plan for up to 30 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the plan administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. In the case of any extension under this paragraph (f)(3), the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a

decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

(4) *Calculating time periods.* For purposes of paragraph (f) of this section, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph (f)(2)(iii) or (f)(3) of this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(g) *Manner and content of notification of benefit determination.* (1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). The notification shall set forth, in a manner calculated to be understood by the claimant—

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

(v) In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits,

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(vi) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

(2) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, the information described in paragraph (g)(1) of this section may be provided to the claimant orally within the time frame prescribed in paragraph (f)(2)(i) of this section, provided that a written or electronic notification in accordance with paragraph (g)(1) of this sec-

tion is furnished to the claimant not later than 3 days after the oral notification.

(h) *Appeal of adverse benefit determinations.* (1) *In general.* Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

(2) *Full and fair review.* Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures—

(i) Provide claimants at least 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether

such information was submitted or considered in the initial benefit determination.

(3) *Group health plans.* The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) through (iv) of this section, the claims procedures—

(i) Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(iv) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(v) Provide that the health care professional engaged for purposes of a consultation under paragraph (h)(3)(iii) of this section shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

(vi) Provide, in the case of a claim involving urgent care, for an expedited review process pursuant to which—

(A) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

(B) All necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

(4) *Plans providing disability benefits.* The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section.

(i) *Timing of notification of benefit determination on review.* (1) *In general.* (i) Except as provided in paragraphs (i)(1)(ii), (i)(2), and (i)(3) of this section, the plan administrator shall notify a claimant in accordance with paragraph (j) of this section of the plan's benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's request for review by the plan, unless the plan administrator determines that special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require an extension of time for processing the claim. If the plan administrator determines that an

extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination on review.

(ii) In the case of a plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(1)(i) of this section shall not apply, and, except as provided in paragraphs (i)(2) and (i)(3) of this section, the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall provide the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but

not later than 5 days after the benefit determination is made.

(2) *Group health plans.* In the case of a group health plan, the plan administrator shall notify a claimant of the plan's benefit determination on review in accordance with paragraphs (i)(2)(i) through (iii), as appropriate.

(i) *Urgent care claims.* In the case of a claim involving urgent care, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the plan.

(ii) *Pre-service claims.* In the case of a pre-service claim, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. In the case of a group health plan that provides for one appeal of an adverse benefit determination, such notification shall be provided not later than 30 days after receipt by the plan of the claimant's request for review of an adverse benefit determination. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 15 days after receipt by the plan of the claimant's request for review of the adverse determination.

(iii) *Post-service claims.* (A) In the case of a post-service claim, except as provided in paragraph (i)(2)(iii)(B) of this section, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review within a reasonable period of

time. In the case of a group health plan that provides for one appeal of an adverse benefit determination, such notification shall be provided not later than 60 days after receipt by the plan of the claimant's request for review of an adverse benefit determination. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 30 days after receipt by the plan of the claimant's request for review of the adverse determination.

(B) In the case of a multiemployer plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(2)(iii)(A) of this section shall not apply, and the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance

with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(3) *Disability claims.* (i) Except as provided in paragraph (i)(3)(ii) of this section, claims involving disability benefits (whether the plan provides for one or two appeals) shall be governed by paragraph (i)(1) of this section, except that a period of 45 days shall apply instead of 60 days for purposes of that paragraph.

(ii) In the case of a multiemployer plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(3)(i) of this section shall not apply, and the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not

later than 5 days after the benefit determination is made.

(4) *Calculating time periods.* For purposes of paragraph (i) of this section, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph (i)(1), (i)(2)(iii)(B), or (i)(3) of this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(5) *Furnishing documents.* In the case of an adverse benefit determination on review, the plan administrator shall provide such access to, and copies of, documents, records, and other information described in paragraphs (j)(3), (j)(4), and (j)(5) of this section as is appropriate.

(j) *Manner and content of notification of benefit determination on review.* The plan administrator shall provide a claimant with written or electronic notification of a plan's benefit determination on review. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant—

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific plan provisions on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to,

and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(4) A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures described in paragraph (c)(3)(iv) of this section, and a statement of the claimant's right to bring an action under section 502(a) of the Act; and

(5) In the case of a group health plan or a plan providing disability benefits—

(i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(iii) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

(k) *Preemption of State law.* (1) Nothing in this section shall be construed to supersede any provision of State law that regulates insurance, except to the extent that such law prevents the application of a requirement of this section.

(2)(i) For purposes of paragraph (k)(1) of this section, a State law regulating insurance shall not be considered to prevent the application of a requirement of this section merely because such State law establishes a review procedure to evaluate and resolve disputes involving adverse benefit determinations under group health plans so long as the review procedure is conducted by a person or entity other than the insurer, the plan, plan fiduciaries, the employer, or any employee or agent of any of the foregoing.

(ii) The State law procedures described in paragraph (k)(2)(i) of this section are not part of the full and fair review required by section 503 of the Act. Claimants therefore need not exhaust such State law procedures prior to bringing suit under section 502(a) of the Act.

(*l*) *Failure to establish and follow reasonable claims procedures.* In the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

(m) *Definitions.* The following terms shall have the meaning ascribed to such terms in this paragraph (m) whenever such term is used in this section:

(1)(i) A "claim involving urgent care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations—

(A) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or,

(B) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(ii) Except as provided in paragraph (m)(1)(iii) of this section, whether a claim is a "claim involving urgent care" within the meaning of paragraph (m)(1)(i)(A) of this section is to be determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(iii) Any claim that a physician with knowledge of the claimant's medical condition determines is a "claim involving urgent care" within the meaning of paragraph (m)(1)(i) of this section shall be treated as a "claim involving urgent care" for purposes of this section.

(2) The term "pre-service claim" means any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(3) The term "post-service claim" means any claim for a benefit under a group health plan that is not a pre-service claim within the meaning of paragraph (m)(2) of this section.

(4) The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or benefi-

ciary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(5) The term "notice" or "notification" means the delivery or furnishing of information to an individual in a manner that satisfies the standards of 29 CFR 2520.104b-1(b) as appropriate with respect to material required to be furnished or made available to an individual.

(6) The term "group health plan" means an employee welfare benefit plan within the meaning of section 3(1) of the Act to the extent that such plan provides "medical care" within the meaning of section 733(a) of the Act.

(7) The term "health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

(8) A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information

(i) Was relied upon in making the benefit determination;

(ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

(iii) Demonstrates compliance with the administrative processes and safeguards required pursuant to

paragraph (b)(5) of this section in making the benefit determination; or

(iv) In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(n) *Apprenticeship plans.* This section does not apply to employee benefit plans that solely provide apprenticeship training benefits.

(o) *Applicability dates.* (1) Except as provided in paragraph (o)(2) of this section, this section shall apply to claims filed under a plan on or after January 1, 2002.

(2) This section shall apply to claims filed under a group health plan on or after the first day of the first plan year beginning on or after July 1, 2002, but in no event later than January 1, 2003.

APPENDIX I

[1998 Version]

CODE OF FEDERAL REGULATIONS

TITLE 29—LABOR

CHAPTER XXV—PENSION AND WELFARE BENEFITS ADMINISTRATION, DEPARTMENT OF

PART 2560--RULES AND REGULATIONS FOR ADMINISTRATION AND ENFORCEMENT

§ 2560.503-1 Claims procedure.

(a) *Scope and purpose.* (1) This section sets out certain minimum requirements for employee benefit plan procedures pertaining to claims by participants and beneficiaries (claimants) for plan benefits, consideration of such claims, and review of claim denials, hereinafter referred to in the aggregate as "claims procedures." Except as otherwise noted, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Employee Retirement Income Security Act of 1974 (the Act).

(b) *Obligation to establish a reasonable claims procedure.* Every employee benefit plan shall establish and maintain reasonable claims procedures.

(1) A claims procedure will be deemed to be reasonable only if it:

(i) Complies with the provisions of paragraphs (d) through (h) of this section, except to the extent that it is deemed to comply with some or all of such provisions under the authority of paragraph (b)(2) or paragraph (j) of this section.

(ii) Is described in the summary plan description, as

required by § 2520.102-3,

(iii) Does not contain any provision, and is not administered in a way, which unduly inhibits or hampers the initiation or processing of plan claims, and

(iv) Provides for informing participants in writing, in a timely fashion, of the time limits set forth in paragraphs (e)(3) and (g)(3) and paragraph (h) of this section.

(2) In the case of a plan established and maintained pursuant to a collective bargaining agreement (other than a plan subject to the provisions of section 302(c)(5) of the Labor Management Relations Act, 1947 concerning joint representation on the board of trustees):

(i) Such plan will be deemed to comply with the provisions of paragraphs (d) through (h) of this section if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference.

(A) Provisions concerning the filing of benefit claims and the initial disposition of benefit claims, and

(B) A grievance and arbitration procedure to which denied claims are subject.

(ii) Such plan will be deemed to comply with the provisions of paragraphs (g) and (h) of this section (but will not be deemed to comply with paragraphs (d) through (f)) if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference a grievance and arbitration procedure to which denied claims are subject (but not provisions concerning the final and initial disposition of benefit claims).

(c) *Claims procedure for an insured welfare or pension plan.*

(1) To the extent that benefits under an employee benefit plan are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of one or more States, the claims procedure pertaining to such benefits may provide for filing of a claim for benefits with and notice of decision by such company, service or organization.

(2) See paragraph (g) regarding review and final decision on denied claims by insurance companies, insurance services and similar organizations.

(d) *Filing of a claim for benefits.* For purposes of this section, a claim is a request for a plan benefit by a participant or beneficiary. A claim is filed when the requirements of a reasonable claim filing procedure of a plan have been met. If a reasonable procedure for filing claims has not been established by the plan, a claim shall be deemed filed when a written or oral communication is made by the claimant or the claimant's authorized representative which is reasonably calculated to bring the claim to the attention of:

(1) In the case of a single employer plan, either the organizational unit which has customarily handled employee benefits matters of the employer, or any officer of the employer.

(2) In the case of a plan to which more than one unaffiliated employer contributes, or which is established or maintained by an employee organization, either the joint board, association, committee or other similar group (or any member of any such group) administering the plan, or the person or organizational unit to which claims for benefits under the plan customarily have been referred.

(3) In the case of a plan the benefits of which are provided or administered by an insurance company, insurance service, or other similar organization, which is subject to regulation under the insurance laws of one or more States, the person or organizational unit which handles claims for benefits under the plan or any officer

of the insurance company, insurance service, or similar organization.

(4) For purposes of paragraphs (d)(1), (2), and (3) of this section, a communication shall be deemed to have been brought to the attention of an organizational unit if it is received by any person employed in such unit.

(e) *Notification to claimant of decision.*

(1) If a claim is wholly or partially denied, notice of the decision, meeting the requirements of paragraph (f) of this section, shall be furnished to the claimant within a reasonable period of time after receipt of the claim by the plan.

(2) If notice of the denial of a claim is not furnished in accordance with paragraph (e)(1) of this section within a reasonable period of time, the claim shall be deemed denied and the claimant shall be permitted to proceed to the review stage described in paragraph (g) of this section.

(3) For purposes of paragraphs (e)(1) and (2), of this section, a period of time will be deemed to be unreasonable if it exceeds 90 days after receipt of the claim by the plan, unless special circumstances require an extension of time for processing the claim. If such an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the final decision.

(f) *Content of notice.* A plan administrator or, if paragraph (c) of this section is applicable, the insurance company, insurance service, or other similar organization, shall provide to every claimant who is denied a claim for benefits written

notice setting forth in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the denial;

(2) Specific reference to pertinent plan provisions on which the denial is based;

(3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

(4) Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review.

(g) *Review procedure.*

(1) Every plan shall establish and maintain a procedure by which a claimant or his duly authorized representative has a reasonable opportunity to appeal a denied claim to an appropriate named fiduciary or to a person designated by such fiduciary, and under which a full and fair review of the claim and its denial may be obtained. Every such procedure shall include but not be limited to provisions that a claimant or his duly authorized representative may:

(i) Request a review upon written application to the plan;

(ii) Review pertinent documents; and

(iii) Submit issues and comments in writing.

(2) To the extent that benefits under an employee benefit plan are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of one or more States, the claims procedure pertaining to such benefits may provide for review of and decision upon denied claims by such company, service or organization. In such case, that company, service, or organiza-

tion shall be the "appropriate named fiduciary" for purposes of this section. In all other cases, the "appropriate named fiduciary" for purposes of this section may be the plan administrator or any other person designated by the plan, provided that such plan administrator or other person is either named in the plan instrument or is identified pursuant to a procedure set forth in the plan as the person who reviews and makes decisions on claim denials.

(3) A plan may establish a limited period within which a claimant must file any request for review of a denied claim. Such time limits must be reasonable and related to the nature of the benefit which is the subject of the claim and to other attendant circumstances. In no event may such a period expire less than 60 days after receipt by the claimant of written notification of denial of a claim.

(h) *Decision on review.*

(1) (i) A decision by an appropriate named fiduciary shall be made promptly, and shall not ordinarily be made later than 60 days after the plan's receipt of a request for review, unless special circumstances (such as the need to hold a hearing, if the plan procedure provides for a hearing) require an extension of time for processing, in which case a decision shall be rendered as soon as possible, but not later than 120 days after receipt of a request for review.

(ii) In the case of a plan with a committee or board of trustees designated as the appropriate named fiduciary, which holds regularly scheduled meetings at least quarterly, a decision on review shall be made by no later than the date of the meeting of the committee or board which immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a decision may be made by no later than the date of the second meeting following the plan's receipt of the request

for review. If special circumstances (such as the need to hold a hearing, if the plan procedure provides for a hearing) require a further extension of time for processing, a decision shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review.

(2) If such an extension of time for review is required because of special circumstances, written notice of the extension shall be furnished to the claimant prior to the commencement of the extension.

(3) The decision on review shall be in writing and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, as well as specific references to the pertinent plan provisions on which the decision is based.

(4) The decision on review shall be furnished to the claimant within the appropriate time described in paragraph (h)(1) of this section. If the decision on review is not furnished within such time, the claim shall be deemed denied on review.

(i) *Apprenticeship plans.* This section does not apply to employee benefit plans which provide solely apprenticeship training benefits.

(j) *Qualified Health Maintenance Organizations.* Claims procedures with respect to any benefits provided through membership in a qualified health maintenance organization, as defined in section 1310(d) of the Public Health Service Act, as amended, 42 U.S.C. § 300e-9(d), shall be deemed to satisfy the requirements of this section with respect to the provision of such benefits to persons who are members of such qualified health maintenance organization, provided those procedures meet the requirements of section 1301 of the Public Health Service Act, as amended 42 U.S.C. 300e and the regulations thereunder.

APPENDIX J

EXECUTION COPY

HEWLETT-PACKARD COMPANY
EMPLOYEE BENEFITS ORGANIZATION
INCOME PROTECTION PLAN

Amended and Restated as of October 1, 1994

HEWLETT-PACKARD COMPANY
EMPLOYEE BENEFITS ORGANIZATION
INCOME PROTECTION PLAN
(Amended and Restated Effective October 1, 1994)

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HEWLETT-PACKARD COMPANY
EMPLOYEE BENEFITS ORGANIZATION
INCOME PROTECTION PLAN
(Amended and Restated Effective October 1, 1994)

SECTION 1. ESTABLISHMENT AND PURPOSE OF PLAN

The Hewlett-Packard Company Employee Benefits Organization Income Protection Plan was adopted effective January 1, 1980, to provide comprehensive disability benefits to Eligible Employees. The Plan was last amended and restated as of October 1, 1994, to read as set forth herein, except that with respect to covered employees located in Puerto Rico, the plan as in effect prior to January 1, 1982, shall remain in effect. Supplement A to the Plan is designed to qualify as a private plan for the payment of temporary disability benefits pursuant to subdivision 5 of Section 211 of the Workers' Compensation Law of New York State. Supplement B to the Plan is designed to qualify as a private plan for the payment of temporary disability benefits pursuant to Section 43:2132 of the New Jersey statutes. Supplement C to the Plan is intended to provide the benefits of a "voluntary plan" established pursuant to Part 2 of the California Unemployment Insurance Code to provide the unemployment compensation disability benefits required by that statute. Voluntary Plan Administrators, Inc. ("VPA") processes and reviews certain claims for benefits under the Plan but does not insure benefits. Certain capitalized terms used in the text of the Plan are defined in Section 2 in alphabetical order. The Plan is a successor to certain sickness and disability plans of the Company, including the Hewlett-Packard Long Term Disability Insurance Plan, the Short Term Disability Plan Waltham/Andover and the Avondale Accident and Sickness Disability Plan, all of which were terminated on December 31, 1979. The Plan is also a successor to the Hewlett-Packard Company California Voluntary Disability Plan (the "California Plan").

SECTION 2. DEFINITIONS

The Following terms shall have the meanings set forth below when capitalized and used in the Plan:

(a) "Claims Administrator" means Voluntary Plan Administrators, Inc. ("VPA"). VPA shall not be deemed to be the plan administrator of the Plan as determined under ERISA.

(c) "Company" means Hewlett-Packard Company, a California corporation.

(d) "Company Contributions" means amounts contributed to the Plan by the Participating Companies, as determined under Section 4.

(d) "ERISA" means the Employee Retirement Income Security Act of 1974, as such Act may be amended from time to time.

(e) "Earnings" means an Eligible Employee's base salary or hourly rate of pay, determined without regard to any "Deferred Contributions" or "Regular Company Contributions" made on the Eligible Employee's behalf to the Hewlett-Packard Company Tax Saving Capital Accumulation Plan, and without regard to any salary reductions made on behalf of an Eligible Employee pursuant to the Hewlett-Packard Company Cafeteria Plan, the Hewlett-Packard Company Health Care Reimbursement Plan and the Hewlett-Packard Company Dependent Care Reimbursement Plan. Earnings shall include flexible time off, sick leave, shift differential, vacation, jury duty, bereavement pay, holidays and other forms of paid time off, but shall exclude overtime, compensation for work in excess of the regular work week, cash profit sharing, bonuses, severance and other post termination payments and (except as provided in the following sentence) commissions. In the case of an Eligible Employee whose compensation is determined in whole or in part on a commission or

other sales related basis, Earnings shall be determined with reference to the Eligible Employee's target amount. In no event shall compensation in excess of that amount prescribed by Section 505(b)(7) of the Internal Revenue Code of 1986 be taken into consideration for any purpose under the Plan. A Member's Earnings shall be determined on a weekly, semimonthly, monthly or annual basis as required by the Plan. The Earnings of a Member whose standard hours of employment are less than full time shall be prorated based on the standard hours per pay period attributed to the Member relative to the standard hours per pay period of a full time employee. Such determination shall be made in the sole discretion of the Company or the Claims Administrator, as applicable. For purposes of determining benefits payable to a Member, Earnings shall be determined with reference to the Member's rate of pay as in effect on the last day the Member was actively at work (or, if later, on flexible time off or holiday) immediately preceding the onset of Total Disability; provided, however, that for the purpose of determining the benefits payable to a Member who becomes Totally Disabled while on a leave of absence or other non-paid employment status, Earnings shall be determined with reference to his or her rate of pay as in effect on the date his or her leave or non-paid employment status commenced, except that in the case of a Member on a personal leave of absence during which he or she will engage in employment for compensation specifically approved in advance in writing by the Company, Earnings shall be the amount of such compensation.

(f) "Eligible Employee" means an individual on the U.S. dollar payroll of a Participating Company who is engaged in regular full time employment or regular part time employment of not less than thirty (30) hours per week; provided, however, that employees who are transferred from a foreign payroll of the

Company or a Subsidiary to the U.S. dollar payroll of a Participating Company shall be Eligible Employees only if they qualify for Eligible Employee status under written guidelines adopted by the Organization (which guidelines may specify that such employees shall be considered to be Eligible Employees solely for purposes of Supplement C), except that any such classification shall not cause any person who would otherwise be eligible for coverage under Supplement C to be ineligible for such coverage. An individual's status as an Eligible Employee shall be determined by the Organization, and such determination shall be conclusive and binding on all persons.

(g) "Hospitalized" means that a Member:

(i) is confined for a period of twenty-four (24) or more hours as a registered bed patient in a hospital (as defined in the California Unemployment Insurance Code);

(ii) is registered as a patient in a surgical clinic (including a surgical clinic licensed by the California State Department of Health Services under Section 1205 of the Health and Safety Code or exempt from such licensing under subdivision (b), (c), (d) or (f) of Section 1206 of such Code); or

(iii) is registered as a patient of a surgical unit located in or operating under the license of a hospital, including ambulatory surgical clinics approved by the Federal Medicare program.

(h) "Investment Manager" means a person who is appointed by the Organization to direct the investment of all or any part of the Trust Fund pursuant to Section 10, whether or not such person is an "investment manager" as such term is defined in Section 3(38) of ERISA.

(i) "Late Applicant" means an Eligible Employee who wishes to enroll or reenroll in the Plan after having elected not to be covered by the Plan.

(j) "Members" means an Eligible Employee who is enrolled in the Plan or a person who is receiving disability benefits pursuant to the Plan.

(k) "Organization" means the Hewlett-Packard Company Employee Benefits Organization, a Delaware non-stock corporation.

(l) "Participating Company" means the Company and those of its Subsidiaries which the Organization has designated to participate in the Plan.

(m) "Plan" means the Hewlett-Packard Company Employee Benefits Organization Income Protection Plan, including all supplements and amendments thereto.

(n) "Plan Year" means the twelve (12) month period commencing October 1 and ending September 30 of each year.

(o) "Rehabilitation Employment" means work in an occupation or employment for profit in which the Member may engage and which either is intended to result in self supporting employment for the Member or is self supporting employment for the Member. Rehabilitation Employment includes work on a substantially reduced basis in the Member's Usual Occupation.

(p) "Subsidiary" means any corporation in which the Company or any Subsidiary owns more than fifty percent (50%) of the outstanding shares of all classes of voting stock.

(q) "Totally Disabled" and "Total Disability" mean that because of injury or sickness:

(i) During the first thirty-nine (39) weeks following the onset of the injury or sickness, the

Member is continuously unable to perform each and every duty of his or her Usual Occupation; and

(ii) After the initial thirty-nine (39) week period, the Member is continuously unable to perform any occupation for which he or she is or may become qualified by reason of his or her education, training or experience.

During the period described in (i) and (ii) above, a Member will not be considered Totally Disabled unless he or she is under the care of a licensed physician. "Licensed physician" means any individual described in Section 2708 of the California Unemployment Insurance Code and includes a physician, surgeon, optometrist, dentist, osteopath, chiropractor, podiatrist, qualified licensed psychologist, and for a normal pregnancy, a licensed nurse, midwife or nurse practitioner. "Under the care of a licensed physician" means the Member has been regularly examined by the licensed physician at home, at the licensed physician's office or at a hospital at a frequency consistent with the Member's injury or illness as determined by the Claims Administrator. The determination of Total Disability shall be made by the Claims Administrator on the basis of objective medical evidence. "Objective medical evidence" shall mean that evidence establishing facts or conditions as perceived without distortion by personal feelings, prejudices or interpretations. A condition caused or contributed to by pregnancy or childbirth which results in the Total Disability of the Member shall be covered under the Plan on the same basis as other Total Disabilities. Any condition diagnosed as or, without regard to its designation is equivalent to, (1) attention deficit disorder (ADD), or (2) chronic fatigue syndrome, Epstein-Barr Virus, or infectious mononucleosis shall be disregarded in the determination of Total Disability during the period described in (ii) above. With respect to any Total Disability caused

or contributed to by mental illness or alcohol or drug abuse, the following limitations shall apply:

(A) Mental Illness

During the period described in (ii) above, in the case of a disability resulting from a nervous or mental disorder, the Member shall be considered Totally Disabled only if he or she is confined to a hospital or other licensed long term care facility for the treatment of such disability or has been so confined for fourteen (14) or more consecutive days during the preceding three (3) months. An illness shall be considered a nervous or mental disorder if:

1. The illness has psychologic or behavioral manifestations or results in impairment of mental functioning due to any causes including, but not limited to, social, psychological, genetic, physical, chemical or biological; and

2. The illness has a primary diagnosis that either is listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised, or falls within diagnostic codes 290 through 319 in the International Classification of Diseases, 9th Revision.

Benefits shall be payable with respect to the period described in (ii) above for no more than sixty-five (65) weeks for any disability resulting from a mental or nervous disorder. The limitations of this Paragraph (A) shall not apply to a Total Disability due to Alzheimers disease, multiple sclerosis, amyotrophic lateral sclerosis, traumatic brain injuries, or other organic, degenerative, progressive diseases as determined by the Claims Administrator.

(B) Alcoholism

In the case of a disability resulting from alcoholism, the Member shall be considered Totally Disabled only during the period described in (i) above and only while being medically treated for acute alcoholism or while a resident in an alcoholic recovery home which is approved by the California State Department of Alcohol and Drug Abuse or some other similar state regulatory agency; provided, however, that benefits shall be payable for a period of no more than thirty (30) days of residency in an alcoholic recovery home during a single period of Total Disability. Benefits shall not be payable during the period described in (ii) above with respect to a disability resulting from alcoholism.

(C) Drug Abuse

In the case of a disability resulting from drug abuse, an Eligible Employee shall be considered Totally Disabled only during the period described in (i) above and only while hospitalized for medical treatment of such disability or while the Member is participating in a medically supervised drug recovery program; provided, however, that benefits shall be payable for a period of no more than thirty (30) days of participation in such a recovery program during a single period of Total Disability. Benefits shall not be payable during the period described in (ii) above with respect to a disability resulting from drug abuse.

(r) "Trust Agreement" means that certain agreement entered into by and between the Organization and the Trustee providing for the maintenance of the Trust Fund.

(s) "Trust Fund" means the fund established and maintained pursuant to the Trust Agreement.

(t) "Trustee" means Boston Safe Deposit and Trust Company, or any successor serving as Trustee under the Plan.

(u) "Usual Occupation" means the normal work assigned to the Member by the Participating Company which employs the Member. If a Member has a condition which permits the performance of the Usual Occupation and the Member's job assignment is changed, such condition will not be considered a Total Disability unless the Member would be considered Totally Disabled for the prior job or the Member has worked on the new job assignment for at least 90 days without time lost due to such condition.

(v) "Waiting Period" means the period described in Section 5(b) which must elapse with respect to each period of disability before benefits become payable to a Member.

SECTION 3. COVERAGE AND MEMBERSHIP

(a) Coverage Automatic

An Eligible Employee shall automatically be covered by the Plan on the latest of:

(i) the date of hire;

(ii) the date he or she first qualifies as an Eligible Employee; or

(iii) January 1, 1982.

Notwithstanding the foregoing, an Eligible Employee who does not wish to be a Member of the Plan may elect not to be covered by the Plan. Such an election shall be effective on the date of the Eligible Employee's initial coverage under the Plan, provided it is filed with the Plan Administrator within thirty (30) days following the date determined pursuant to the first sentence of this Section 3(a). In all other cases the election not to be cov-

ered by the Plan shall be effective on the first day of the calendar quarter next following the date the election was filed. A Late Applicant who is eligible for coverage under Supplement C shall be eligible to enroll or reenroll in the Plan on the first day of the calendar quarter following his or her election to enroll or reenroll in the Plan, provided he or she has completed three (3) months of employment on such day; provided, further, that such a Late Applicant shall be eligible for the benefits described in Section 5 only upon presentation of evidence of good health acceptable to the Claims Administrator. All other Late Applicants may enroll in the Plan only upon presentation of evidence of good health acceptable to the Claims Administrator. Such evidence, which may include a physical examination, shall be obtained at the expense of the Eligible Employee.

(b) Effective Date of Membership

If an Eligible Employee does not elect not to be covered by the Plan when first eligible for membership or within thirty (30) days thereafter, membership in the Plan commences on the date specified in the first sentence of Section 3(a) above; provided, however, in the case of an Eligible Employee who is not actively at work on the date his or her membership would be effective pursuant to the foregoing sentence, his or her membership shall not be effective until he or she returns to active work. Membership of an Eligible Employee who enrolls or reenrolls as a Late Applicant shall commence on the date described in Section 3(a) above, but eligibility of a Late Applicant who is eligible for coverage under Supplement C for the benefits described in Section 5 shall commence only on the date of acceptance of the application by the Claims Administrator.

(c) Continuation of Membership for Members on Leaves of Absence and in Nonpaid Employment Status

Membership in the Plan shall be continued during any period a Member is on a Company approved medical or personal leave on absence, leave of absence required by the federal Family and Medical Leave Act, military leave of absence or in any other Company approved nonpaid employment status.

(d) Suspension of Membership

Unless a Member satisfies the condition of Section 3(c) above, membership in the Plan shall be suspended during any period a Member ceases to qualify as an Eligible Employee, even though there is no termination of his or her employment relationship with the Company and its Subsidiaries. The foregoing sentence notwithstanding, if an Employee covered under Supplement C whose membership in the Plan is suspended due to failure to satisfy the condition of Section 3(c) above becomes Totally Disabled during the first fifteen (15) calendar days following the commencement of a leave of absence without pay, he or she shall be treated as an Eligible Employee for all purposes under the Plan, except that no benefits shall be payable to such a California Employee under Section 5. The membership of a suspended Member shall be reinstated effective on the date the Member returns to active employment as an Eligible Employee.

(e) Termination of Membership

Membership in the Plan shall terminate upon the Member's death, termination of his or her employment relationship with the Company and any Subsidiary, or on the first day of the calendar quarter following the filing of his or her election not to be covered by the Plan, unless at the time of such termination he or she is Totally Disabled and eligible for or receiving benefits under the Plan. Membership in the Plan shall also terminate in the event of

the termination of the Plan as provided in Section 10.

SECTION 4. FUNDING POLICY AND METHOD OF PAYMENTS TO AND FROM PLAN

(a) Company Contributions

The Organization shall from time to time determine the amount of contributions necessary to maintain the Plan on an actuarially sound basis. Effective January 1, 1982, the Participating Companies shall pay the entire amount of such contributions determined by the Organization.

(b) Contributions Required by Law

Notwithstanding Section 4(a) above, any Company Contribution shall be reduced (but not below zero) by the amount the Participating Company is required by law to pay (whether by payroll deduction or otherwise) to any state disability insurance fund or similar arrangement.

(c) Collection of Company Contributions Company contributions to the plan shall be transmitted to the Trustee as required to satisfy the obligations of the Plan.

(d) No Company Guarantee

The Company's obligation to make contributions to the Plan shall be limited to the amount of Company Contributions determined pursuant to Sections 4(a) and (b) above and the Company shall not be under any obligation to contribute additional amounts to the Plan for any reason whatsoever; provided, however, that in the event that the assets of the Plan are insufficient upon termination of the Plan to pay the benefits described in Supplement A or B or benefits payable under Supplement C not in excess of the "State Fund Benefit" described therein to Members who are Totally Disabled on the date of such termi-

nation, the Company shall contribute such additional amounts as may be necessary to provide such benefits.

(e) Contributions Held in Trust

All Company Contributions to the Plan will be transmitted to the Trustee and will be held (together with the income gains and losses attributable thereto) in a Trust Fund established pursuant to the Trust Agreement entered into by the Organization and the Trustee. To the extent not required to pay benefits or administrative costs of the Plan, the Trust Fund shall be held and invested by the Trustee for the exclusive benefit of Members. Administrative expenses of the Plan shall be paid out of the Trust Fund, except to the extent they are paid by the Company or offset against any required Company Contribution.

(f) Payment of Benefit

Benefits under the Plan will be paid by the Organization out of the Trust Fund, and the Organization shall have no obligation to provide benefits under the Plan in the event the Trust Fund is insufficient for that purpose. The Claims Administrator will be responsible for the processing of claims. The disbursement of benefits from the Trust Fund will be made through the Company's payroll system by the Company as agent for the Organization and the Claims Administrator.

The Organization may, in its discretion, enter into an insurance contract with one or more insurance carriers pursuant to which any or all of the benefits provided by the Plan shall be insured; provided, however, that insurance shall be obtained with respect to any benefits described in Supplement C only to the extent permitted and in the manner prescribed by the California Unemployment Insurance Code and regulations promulgated thereunder.

SECTION 5. DISABILITY BENEFIT

(a) Amount of Benefit

Except as provided in Section 3(d) and subsection 5(d) and (k) below, a Member who becomes Totally Disabled shall receive:

(i) During the first thirty-nine (39) weeks of Total Disability, a monthly benefit equal to seventy-five percent (75%) of his or her monthly Earnings (as determined by the Claims Administrator); and

(b) After the initial thirty-nine (39) week period of Total Disability, a monthly benefit equal to seventy-five percent (75%) of the first three thousand dollars ($3,000) of his or her monthly Earnings (as determined by the Claims Administrator), and fifty percent (50%) of such Earnings in excess of three thousand dollars ($3,000).

The benefit described in the foregoing sentence shall be reduced by the items described in subsections 5(e), (g), (h) and (k) below. Notwithstanding any provision of this Plan to the contrary, no benefits shall be paid under the Plan with respect to any period during which the Member is eligible to make an election for additional maintenance allowance pursuant to Section 139.5 (d)(2) of the California Labor Code and does not make such election.

(b) Waiting Period: Commencement of Benefit

Payment of the benefit under this Section 5 shall commence as of the eighth (8th) consecutive calendar day of the Member's Total Disability; provided, however, that if the Member is Hospitalized before such eighth (8th) calendar day, such benefit shall commence on the first day of such Hospitalization; provided, further, that in the case of a Member who is covered by Supplement C, payment of the benefit

under this Section 5 shall commence after the Member has received fifty-two (52) weekly benefit payments or the equivalent thereof under Supplement C, provided the Member continues to be Totally Disabled at that time. In the case of a Member who is Totally Disabled pursuant to Section 2(q)(i) while on a medical leave of absence, no more than thirty-nine (39) weeks of benefits payable by reason of Section 2(q)(i) shall be paid with respect to a single continuous period of medical leave of absence. Notwithstanding the foregoing, in the case of a Member who becomes Totally Disabled while on a personal leave of absence or military leave of absence, no benefit shall be payable with respect to any period prior to the scheduled expiration date of the personal leave of absence or military leave of absence.

(c) Duration of Benefit

A Member who is receiving the benefit under this Section 5 shall continue to do so until the earliest of the following dates:

(i) The date the Member is found to be no longer Totally Disabled;

(ii) The date the Member willfully and without justifiable cause fails to accept reasonable medical treatment which would be likely to alleviate or cure the Member's Total Disability, as determined by the Claims Administrator;

(iii) The date following the day the Member dies;

(iv) The date the Member becomes self-employed or the employee of another employer without previously having given written notice of such employment to the Claims Administrator and receiving approval pursuant to Section 5(i);

(v) The date the Member willfully and without justifiable cause refuses to be examined by a physician selected by the Claims Administrator; or

(vi) The first day of the month following the month in which the Member attains age sixty-five (65), except that if a Member becomes Totally Disabled on or after his or her sixty-first (61st) birthday, his or her benefits shall be payable for the period determined with reference to the following table:

Age at Onset of Total Disability	Date Benefits Terminate
61 but not yet 62	4 years after onset of Total Disability
62 but not yet 63	3 1/2 years after onset of Total Disability
63 but not yet 64	3 years after onset of Total Disability
64 but not yet 65	2 1/2 years after onset of Total Disability
65 but not yet 66	2 years after onset of Total Disability
66 but not yet 67	1 3/4 years after onset of Total Disability
67 but not yet 68	1 1/2 years after onset of Total Disability
68 but not yet 69	1 1/4 years after onset of Total Disability
69 or older	1 year after onset of Total Disability

(d) Exclusions

Notwithstanding the foregoing, benefits under this Section 5 shall not be payable for a Total Disability caused by or contributed to by any of the following:

(i) War or act of war, whether declared or not, or civil insurrection;

(ii) Engaging in the commission of a felony or riot; or

(iii) Service in the armed forces of any country or international authority.

(e) Offsets

In determining the actual benefit to be paid under the Plan, a Member's benefit determined under Section 5(a) above shall be reduced by any benefit payable to the Member under Supplement A, B or C, and any income or payments available to or for the benefit of the Member or his or her spouse or child by reason of the Member's Total Disability or age from any of the following sources:

(i) State, Federal and any foreign governmental disability benefits including, but not limited to, Social Security benefits (primary and family) and benefits under the California State Disability Fund;

(ii) Worker's compensation and other similar disability payments required by law including, without limitation, payments attributable to temporary disability, permanent disability, permanent/partial disability, vocational rehabilitation payments, rehabilitation maintenance allowance payments, compromise and release settlements and lump sum settlements, but excluding medical expenses incurred prior to the award. At the discretion of the Claims Administrator, Plan benefits may be paid to the Member pending determination of his or her entitlement to, or prior to his or her receipt of, the benefits specified in the previous sentence. In such case, payment of Plan benefits shall be contingent upon the Member's agreement that, in the event of receipt by the Member of any lump sum payment of the benefits specified in the previous sentence, he or she will reimburse the Plan for benefits so paid, up to the amount of such lump sum payment and that any portion

of the lump sum payment which is not applied to such reimbursement shall serve to reduce Plan benefits payable after the Member's receipt of the lump sum benefit;

(iii) Benefits under any disability benefits program for which the Company or any other employer permits payroll deductions or makes contributions or direct payments to covered employees, including the California Plan;

(iv) The amount of any award or settlement the Member receives due to the acts or omissions of a third party if the Member's Total Disability is the result of the act or omission of such third party, and the amount of any payments the Members receives under any no fault provision of an insurance contract with respect to any injury which results in the Member's Total Disability;

(v) Federal Social Security benefits (primary and family) payable by reason of the Member's age; and

(vi) In the case of a Member who is receiving benefits under the Plan after he or she attains age sixty-five (65), the amount of any benefit that would be payable to the Member under the Hewlett-Packard Company Deferred Profit Sharing Plan and the Hewlett-Packard Company Retirement Plan as of his or her normal retirement date (as defined in such plans) as a single life annuity, whether or not the Member elected such form or time of payment.

For the purpose of applying the Social Security offset described in (i) and (v) above, except as provided in the immediately following sentence, such offset shall commence as of the date Social Security benefits would become payable during a period of Total Disability whether or not such benefits are

then being received by or paid on behalf of the Member. If eligibility for Social Security benefits has not been determined as of the date the offset referred to in the immediately preceding sentence would otherwise commence, the Member may defer any reduction in benefits under the Plan due to such offset by entering into an agreement, in writing, with the Claims Administrator which agreement shall include, but not be limited to, the following: a commitment to repay to the Plan any Social Security benefits awarded, an authorization to the Social Security Administration to release information to the Claims Administrator, and evidence that the Member has applied for Social Security benefits and, if initially declined, evidence that the Member has requested reconsideration of the denial. If the Member's application for Social Security benefits is denied by the Social Security Administration, the Member is required to submit an application for reconsideration to the Social Security Administration. If the reconsideration request is denied, the Member is then required to request a hearing before the Administrative Law Judge level of the Social Security Administration. If the claim is denied at the Administrative Law Judge level, at the request of the Claims Administrator, the Member may be required to submit a reapplication for benefits. Upon the Member's request, the Claims Administrator will provide assistance in submitting the needed information to support an appeal.

When computing and paying a Member's monthly benefit, the Claims Administrator shall use the actual primary and family benefits paid to or on behalf of the Member under the Social Security Act; provided, however, that in the event the Social Security Administration has not made a determination of the Member's entitlement to Social Security benefits at the time the offset is to be applied and the Member has not entered into an agreement with the Claims

Administrator as described above, or has not requested reconsideration of a declination by the Social Security Administration, or a hearing before the Administrative Law Judge level, or if requested by the Claims Administrator, reapplied for benefits, the Claims Administrator shall assume that the Member has duly made a claim for Social Security benefits and is entitled to the maximum primary and family benefits payable under the Social Security Act, based on estimates determined on a uniform basis by the Claims Administrator, and shall continue to apply the offset in such manner unless and until the Member furnishes the Claims Administrator with either a denial letter showing that the Social Security Administration has determined that the Member is not entitled to such benefits initially and upon reconsideration and, if required by the Claims Administrator, upon reapplication, or an approval letter showing that the amount of such benefits to which the Member is entitled is less than that which was assumed by the Claims Administrator.

After the Social Security Administration has made a determination as to the Member's eligibility for benefits, the Member must inform the Claims Administrator of such determination. The Claims Administrator shall then either compute the Member's monthly benefits for which no Social Security benefit was offset based on the Social Security benefit awarded (assuming the Member has entered into an agreement with the Claims Administrator as described above) or recompute the Member's monthly benefits for which an assumed Social Security benefit was offset. If any recomputation results in an underpayment to the Member, the Member shall be reimbursed in the amount of such underpayment. If an overpayment to the Member has occurred, the Organization shall take all such steps which may be necessary and desirable to recover the amount of such overpayment as provided in Section 11(a).

(f) Maximum Social Security Offset

After a Member becomes eligible for and commences receiving benefits under the Plan, the Social Security offset shall not exceed an amount determined as follows:

(i) During the period the Member is eligible for and receiving Social Security disability benefits, the amount payable at the date of commencement of payment of the Member's Social Security disability benefits; and

(ii) During the period the Member is eligible for and receiving Social Security old age benefits, the amount payable at the date the Member first commenced receiving such old age benefits.

Subsequent general increases in Social Security or other legal benefits shall not affect benefits which are in pay status.

(g) Effect of Rehabilitation Employment

With the consent of the Claims Administrator, a Member may engage in Rehabilitation Employment for up to three (3) months without jeopardizing the Member's eligibility for benefits under this Section 5. Such three (3) month period may be extended by the Claims Administrator from time to time for additional three (3) month periods, but the aggregate duration of Rehabilitation Employment shall not exceed one year for any single period of disability. Such Rehabilitation Employment shall not be considered as a return to work requiring a new Waiting Period. During a period of Rehabilitation Employment the Member shall receive a monthly benefit equal to seventy-five percent (75%) times the difference between the Member's monthly Earnings at the onset of Total Disability (as determined by the Claims Administrator) less the Member's monthly earnings attributable to Rehabilitation Employment

(as determined by the Claims Administrator). A Member's employment prior and subsequent to sessions of chemotherapy and radiation therapy treatments shall be considered Rehabilitation Employment subject to this Section 5(g).

(h) Effect of Employment or Self Employment Other Than Rehabilitation Employment

If a Member, while receiving Plan benefits, continues to be Totally Disabled but is employed (on either a full or part time basis) or is self employed for profit in a capacity which does not constitute Rehabilitation Employment, earnings or profits from such employment will be offset in full against the Member's benefits under this Section 5.

(i) Advance Approval of Employment

If a Member who is receiving benefits under the Plan wishes to become self employed or to work for others (on either a full or part time basis), such Member must obtain advance written approval of such employment from the Claims Administrator. If the Member fails to obtain such approval and such failure is not due to a reasonable cause, effective as of the commencement of such employment, the Member shall cease to be eligible to receive benefits under this Section 5.

(j) Frequency of Payment

Benefits shall be paid under this Section 5 on a semimonthly basis, provided that with the consent of the Organization benefits may be paid under this Section 5 on a weekly or monthly basis if an appropriate adjustment is made in the amount of each such payment.

(k) Company Payroll Deductions

With the consent of the Member, any payroll deductions authorized to be taken from pay received from

the Company shall continue to be deducted from benefits paid under this Section 5. The Member may terminate any such deductions upon written notice to the Company.

(l) Acts of Third Parties

In the event that a Member is injured through the acts or omissions of another person or organization, benefits under the Plan shall be provided only on the condition that the Member agrees in writing to the following:

(i) To reimburse the Plan for the full amount of benefits paid under the Plan. Such amounts shall be payable immediately upon the receipt of any damages collected by the Member against a third party, whether in a legal judgment, settlement, or otherwise, net of the Member's reasonable expenses in collecting such amount including reasonable attorney's fees and of any amounts which are allocated under the terms of any judgment for the payment of unreimbursed medical expenses of the Member; provided, however, that collection from the Member's own insurance company ("first party" insurance) under any Uninsured Motorist or similar coverage for the acts or omissions of another person or organization shall be deemed receipt of damages collected against a third party for all purpose of this Section 5(1);

(ii) To execute and deliver such instruments and do whatever else is reasonably necessary to secure the Plan's right of reimbursement out of such proceeds;

(iii) To provide the Plan with a lien against any damages collected by the Member against a third party, whether in a legal judgment, settlement, or otherwise. Said lien shall be equal to

the total amount of all benefits paid under the Plan; and

(iv) To agree to a credit against payments to be made under the Plan in the future equal to the amount of any damages collected by the Member against a third party, whether by legal judgment, settlement or otherwise, less any amount paid to the Plan pursuant to (i) above.

In the event that the Member fails to comply with the requirements of this Section 5(1), he or she shall not be eligible to receive any further benefits under the Plan until he or she has so complied.

The Claims Administrator shall have the right to intervene in any suit or other proceeding to protect the reimbursement rights hereunder. The Member shall be responsible for all fees of the attorney handling the claim against the third party.

SECTION 6. BENEFIT PAYMENTS FOR INCOMPETENT MEMBERS

Benefits for any Member who is incompetent and unable to manage his or her affairs will be paid to the guardian or conservator of such Member's estate, or, if none has been appointed, to the Member's spouse. If the Member is separated or estranged from such spouse or does not have a spouse, or if the spouse is also incompetent, payments shall then be payable to any person or persons whom the Organization determines to have accepted competent responsibility for the care of such Member. Any payments which are made to someone other than the Member shall be applied solely for the care and benefit of such Member.

SECTION 7. CLAIMS PROCEDURE

(a) After the Member informs the Company that he or she is unable to work due to an illness or injury, the Company shall notify the Claims Administrator of a potential claim for benefits under the Plan within

sixty (60) days after the commencement of the Total Disability, unless the Company's failure to give such notice is due to good cause, as determined by the Organization.

(b) As a condition to the receipt of benefits hereunder, a Member who has a claim for benefits under the Plan shall file such claim with the Claims Administrator within sixty (60) days following the date of onset of Total Disability on the form prescribed by the Organization. Should a claim not be filed within sixty (60) days following the date of onset of Total Disability, no benefits shall be paid with respect to the period beginning with the onset of Total Disability and ending sixty (60) days prior to the day the claim is postmarked (which period shall be referred to as the "Benefit Suspension Period"). Provided, however, that if it is shown that a timely claim was not filed due to an absence of legal capacity, there shall be no reduction in benefits paid with respect to the Benefit Suspension Period. Provided, further, that with respect to claims paid under Supplement C, benefits in an amount equal to the State Fund Benefit as described in Section 5 of Supplement C shall be paid during the Benefit Suspension Period. The prescribed form must be signed by the Member, or, in the case of incompetency or incapacity of the Member, by the Member's legal representative on the Member's behalf.

After the Claims Administrator has reviewed the claim form and obtained any other information which pursuant to its customary procedure it may deem necessary or desirable in order to render a decision on the claim, the Claims Administrator shall notify the Member within a reasonable period of time after receipt of the application of the acceptance or denial of the Member's claim. The Member shall be solely responsible for submitting the claim form and any other information or evidence

on which the Member intends the Claims Administrator to consider in order to render a decision on the claim. In the event the claim for benefits is accepted, the Claims Administrator will direct the Company to commence payments as soon as administratively practicable. During the first thirty-nine (39) week period of Total Disability, the Claims Administrator shall periodically reassess the eligibility for benefits based on the diagnosis, prognosis, treatment plan, adequacy of documentation submitted to date, and such other factors as the Claims Administrator shall select consistent with the Claims Administrator's standard procedures. If the Member is determined to be eligible for benefits after the initial thirty-nine (39) week period of Total Disability, the Claims Administrator shall reassess the continued eligibility for benefits on an annual or semi-annual basis consistent with the Claims Administrator's standard procedures. The Member shall provide such documentary information and submit to such medical examination as the Claims Administrator shall request in support of periodic reassessment for benefits.

(c) In the event any claim for benefits is denied, in whole or in part, the Claims Administrator shall notify the claimant of such denial in writing and shall advise the claimant of his or her right to appeal the denial. If the claim for benefits of an Employee covered under Supplement C is denied, notice of such denial shall be given promptly and in no event later than ninety (90) days after the Claims Administrator receives the claim (one hundred eighty (180) days, if special circumstances require additional time for processing). In such case, notice of denial shall also be given to the California Department of Human Resources Development. Such written notice shall be given to the claimant within ninety (90) days after the Claims Administrator receives the claim, unless special circumstances require addi-

tional time for processing. If additional time for processing is required, written notice shall be furnished to the claimant prior to the termination of the initial ninety (90) day period. Such notice shall indicate the special circumstances requiring the extension of time and the date by which the Claims Administrator expects to render its decision on the claim for benefits. If a claimant has not received written notice that additional time is required for processing his or her claim for benefits within ninety (90) days of the date it is received by the Claims Administrator, the claim shall be deemed to have been denied and the claimant shall be permitted to appeal such denial in accordance with the review procedure described in Section 8. If a Claimant receives proper and timely notice that additional time is required for processing his or her claim for benefits but does not receive written notice of the Claims Administrator's decision with respect to the claim within one hundred eighty (180) days after the date the claim is received by the Claims Administrator, the claim shall be deemed to have been denied and the claimant shall be permitted to appeal such denial in accordance with the review procedure described in Section 8.

SECTION 8. REVIEW OF DENIED CLAIMS

(a) Named Fiduciary

The Organization is the named fiduciary which has the discretionary authority to act with respect to any appeal from a denial of benefits. The Organization's discretionary authority includes the authority to determine eligibility for benefits and to construe the terms of the Plan. The Claims Administrator shall administer the review of denied claims on the Organization's behalf and make the decision on review.

(b) Right to Appeal

Any person whose claim for benefits is denied (or deemed denied), in whole or in part, or such person's authorized representative, may appeal from the denial by submitting a written request for review of the claim to the Claims Administrator within sixty (60) days after receiving written notice of the denial from the Claim, Administrator (or, in the case of a deemed denial, within sixty (60) days after the date the claim is deemed denied). The Claims Administrator shall give the claimant (or the claimant's representative) an opportunity to review pertinent documents (other than legally privileged documents) in preparing a request for review. A request for review shall set forth all of the grounds upon which it is based, all facts in support thereof and any other matters which the claimant deems pertinent. The Member shall be solely responsible for submitting a written request for review of the claim and any other information or evidence on which the Member intends the Claims Administrator to consider in order to render a decision on review. The Claims Administrator may require the claimant to submit such additional facts, documents or other material as it may deem necessary or appropriate in making its review. An Employee whose claim for benefits under Supplement C is denied shall also have the right to appeal the denial in the manner provided by law and authorized regulations for an appeal on a claim for benefits payable out of the California State Disability Fund.

(c) Decision on Review

The Claims Administrator shall act upon each request for review within sixty (60) days after receipt thereof, unless special circumstances require additional time for review. If additional time for review is required, written notice shall be furnished to the Claimant prior to the end of the initial sixty (60) day period, indicating the date by which the Claims

Administrator expects to render its decision on the request for review. In no event shall the decision of the Claims Administrator be rendered more than one hundred twenty (120) days after it receives the request for review.

The Claims Administrator will make the decision on review in conformance with procedures it has developed in the normal course of its business, and the claimant will be notified promptly and in writing of the decision. The Claims Administrator shall have the discretionary power to construe the language of the Plan and make the decision on review on behalf of the Organization. To the extent the Plan language does not address a claim or to the extent the Claims Administrator is unable to construe the Plan language, the Claims Administrator shall consult with the Organization prior to making a decision on review.

Within the time prescribed above, the Claims Administrator shall give written notice of its decision to the claimant and the Organization. If it is determined on review that benefits are payable under the Plan, the Claims Administrator shall proceed to direct the Company to pay such benefit. In the event the Claims Administrator confirms the denial of the claim for benefits, in whole or in part, such notice shall set forth, in a manner calculated to be understood by the claimant, the specific reasons for such denial and specific references to the Plan provisions on which the decision was based.

If a claimant has not received written notice that additional time is required for review within sixty (60) days of the date his or her request for review is reached by the Claims Administrator, the claim shall be deemed to have been denied on review. If a claimant receives proper and timely notice that additional time is required for review, but does not receive written notice of the Claims Administrator's

decision with respect to his or her claim within one hundred twenty (120) days after the date the Claims Administrator receives the request for review, the claim shall be deemed to have been denied on review.

(d) Exhaustion of Remedies

No action at law or equity shall be brought to recover benefits under the Plan unless the action is commenced within four (4) years after the occurrence of the loss for which a claim is made. Except as provided in Section 3264 of the California Unemployment Insurance Code (as applicable), no action at law or equity shall be brought to recover a benefit under the Plan unless and until the claimant has:

(i) submitted a written application for benefits;

(ii) been notified by the Claims Administrator that the application is denied (or the application is deemed denied);

(iii) filed a written request for a review of the application with the Claims Administrator; and

(iv) been notified in writing that the denial of the application has been affirmed (or the denial of the application is deemed to have been affirmed).

SECTION 9. ADMINISTRATION AND OPERATION OF THE PLAN

The Organization is the "plan administrator" and "plan sponsor" as such terms are used in ERISA. The Organization, in its capacity as the plan administrator, is the named fiduciary which has the discretionary authority to control and manage the operation and administration of the Plan. In its discretion it may adopt rules and regulations under the Plan and interpret the Plan text; provided, however, that any such rule, regulation or interpretation

which affects any matter involving Supplement C shall be consistent with applicable requirements of the California Unemployment Insurance Code and regulations promulgated thereunder. The Organization will discharge its duties under the Plan in accordance with the standards set forth in Section 404(a)(1) of ERISA. The Organization is the named fiduciary with respect to control over or management of assets of the Plan only to the extent that it (a) shall appoint the Trustee; and (b) has the authority to appoint one or more Investment Managers for any assets held in Trust pursuant to the Plan.

The trustee shall have the exclusive authority and discretion to manage and control the Trust Fund, except to the extent that the authority to manage, acquire and dispose of such assets is allocated by the Organization to one or more Investment Managers. Each Investment Manager shall have the power to manage, including the power to acquire and dispose of, those assets held in trust pursuant to the Plan which are assigned to it by the Organization.

The Organization shall carry out its duties and responsibilities under the Plan through its directors, officers and employees, acting on behalf of and in the name of the Organization in their capacities as directors, officers and employees and not as individual fiduciaries. The Organization may employ other persons to render advice or to perform services with regard to its responsibilities under the Plan. These persons may include (without limitation) accountants, actuaries, attorneys, claims administrators and consultants. The Organization may delegate to the Company or any claims administrator any of its responsibilities and rights as plan administrator.

SECTION 10. AMENDMENT AND TERMINATION OF THE PLAN

The Organization expects to continue the Plan indefinitely. Future conditions, however, cannot be foreseen, and the Organization reserves the right to amend or to terminate the Plan at any time by resolution of the Or-

ganization's board of directors or by resolution or other documented action by any proper delegatee of the Organization's board of directors. Any amendment designed to bring the Plan into compliance with any applicable state law shall be fully effective as an act of the Organization if it is executed by an officer of the Organization. No amendment or termination of the Plan, however, shall adversely affect any claim for benefits under the Plan incurred prior to the effective date of such amendment or termination (to the extent that assets are available in the Trust Fund for the payment of such claims). Any amendment affecting the benefits provided in Supplement C not in excess of the "State Fund Benefit" described therein shall be adopted subject to the approval of the California Employment Development Department in the manner described in Section 3271 of the California Unemployment Insurance Code.

In the event of termination of the Plan, no part of the Trust Fund shall revert to any Member (other than through the payment of benefits under the Plan), director or officer of the Organization or any individual or be used or diverted for purposes other than for the exclusive purpose of providing benefits for Members pursuant to the Plan or in a manner consistent with the purposes of the Plan, as determined by the Organization.

Upon termination of the Plan, the assets of the Plan shall first be allocated to the payment of the benefits described in Supplement A and B and the benefits payable under Supplement C not in excess of the "State Fund Benefit" described therein, and any assets of the Plan remaining after such allocation shall be allocated to provide the benefits payable under Section 5 or under Supplement C in excess of such "State Fund Benefit." The Organization shall have no further liability in excess of such assets in connection with the Plan.

SECTION 11. GENERAL PROVISIONS

(a) Overpayments

In the event that the calculation of a Member's benefit under the Plan results in an overpayment to the Member for any reason, the Member shall be required to repay such overpayment to the Organization; provided, however, that for purposes of Supplement C, a Member will be liable for the repayment of that portion of the benefit which would represent the amount of the 'State Fund Benefit' described under Supplement C only to the extent permitted under Section 2735 of the California Unemployment Insurance Code. The Organization may (but is not required to) make reasonable arrangements with the Member or his or her legal representative for the repayment to the Organization of such overpayment, including (but not limited to) the reduction of future benefits under the Plan or the reduction of future pay from the Company.

(b) Recurring Disabilities

A recurring Total Disability shall be treated as a single continuous period of disability and the Member shall be entitled to continue to receive benefits and shall not be required to satisfy another Waiting Period if the periods of Total Disability are attributable to the same or related causes and the periods of Total Disability are separated by a return to active work as an Eligible Employee (other than in Rehabilitation Employment) which does not exceed fourteen (14) calendar days. In such case, for purposes of determining the Member's benefits under the Plan, Earnings shall be determined as of the date of original onset of Total Disability.

(c) Overlapping Disabilities

When a Member has two or more separated and unrelated Total Disabilities for periods which overlap, only one Waiting Period must be satisfied and a single uninterrupted period of disability exists.

(d) Information Required

Any Member who willfully and without justifiable cause fails or refuses to comply in a timely manner with any reasonable request by the Organization, the Company or the Claims Administrator for information about such Member's claim for benefits under the Plan (including but not limited to claim forms, medical information and medical information release forms) shall not be eligible to receive benefits under the Plan; provided, however, that such Member's eligibility for benefits shall be reinstated upon compliance with such request or upon a demonstration to the satisfaction of the Claims Administrator that under the circumstances the request is not reasonable.

(e) Choice of Law

The Plan, and all rights under the Plan, shall be interpreted and construed in accordance with ERISA and, to the extent that state laws are not preempted by ERISA, the law of the State of California.

(f) Lump Sum Payment

No claim under the Plan may be resolved by lump sum payment without the written consent of the Organization.

(g) No Assignment of Property Rights

The interest and property rights of any person in the Plan or in any payment to be made under the Plan shall not be subject to option or be assignable either by voluntary or involuntary assignment or by operation of law, including bankruptcy; provided, however, that nothing herein shall prohibit the satisfaction of a creditor's claim through levy, garnishment, execution, attachment, or other creditor's process for recovery or collection of a debt, unless, with respect to the amount of disability benefits required to be paid pursuant to state law as established in Supplements A, B and C of the Plan, such satisfaction is

prohibited by state law. Any act in violation of this Section 11(g) shall be void.

(h) Worker's Compensation

The Plan is not in lieu of, and does not affect any requirement for coverage by, workers' compensation insurance.

(i) Employment Rights

Nothing in this Plan shall be deemed to give any person a right to remain in the employ of the Company nor affect any right of the Company to terminate the employment of any person with or without cause.

(j) Number

Except as otherwise clearly indicated, the singular shall include the plural, and vice versa.

(k) Headings and Captions

The headings and captions herein are provided for reference and convenience only and shall not be considered part of the Plan nor shall they be employed in the construction of the Plan.

(l) Severability of Provisions

If any provision of the Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof, and the Plan shall be construed and enforced as if such provision had not been included.

(m) Inconsistent State Laws

To the extent that any state law is not preempted by ERISA and such law requires greater benefits than those provided under the Plan, the Plan shall be administered in conformance with such state law.

SECTION 12. EXECUTION

To record the amendment of the Plan to read as set forth herein, the Organization has caused its authorized officers to affix the corporate name and seal hereto this 9th day of February, 1995.

HEWLETT-PACKARD COMPANY EMPLOYEE BENEFITS ORGANIZATION

By: /s/
Pete Peterson, President

Attest: /s/
Abraham Lev, Secretary

SUPPLEMENT A

TEMPORARY DISABILITY BENEFITS FOR NEW YORK EMPLOYEES

SUPPLEMENT B

THE HEWLETT-PACKARD COMPANY

EMPLOYEE BENEFITS ORGANIZATION PRIVATE PLAN OF TEMPORARY DISABILITY BENEFITS FOR NEW JERSEY EMPLOYEES

SUPPLEMENT C

TEMPORARY DISABILITY BENEFITS FOR CALIFORNIA EMPLOYEES

EXECUTION COPY

AMENDMENT TO THE HEWLETT-PACKARD COMPANY EMPLOYEE BENEFITS ORGANIZATION INCOME PROTECTION PLAN

(Amended and Restated as of October 1, 1994)

The following amendments to the Hewlett-Packard Company Employee Benefits Organization Protection Plan, amended and restated as of October 1, 1994, are adopted by the Hewlett-Packard Company Employee Benefits Organization:

1. Effective November 1, 1997 Section 2(e) shall be restated to read as follows:

> "Earnings" means an eligible Employee's base salary or hourly rate of pay, determined without regard to any "Deferred Contributions" or "Regular Company Contributions" made on the Eligible Employee's behalf to the Hewlett-Packard Company Tax Savings Capital Accumulation Plan, and without regard to any salary reductions made on behalf of an Eligible Employee pursuant to the Hewlett-Packard Company Cafeteria Plan, the Hewlett-Packard Company Health Care Reimbursement Plan, the Hewlett-Packard Company Dependent Care Reimbursement Plan and the Hewlett-Packard Company Executive Deferred Compensation Plan. Earnings shall include flexible time off, sick leave, shift differential, vacation, jury duty, bereavement pay, holidays, and other forms of paid time off, but shall exclude overtime, compensation for work in excess of the regular work week, cash profit sharing, bonuses, severance and other post termination payments and (except as provided in the following sentence) commissions. In the case of an Eligible Employee whose compensation is determined in whole or in part on a commission or other sales related basis, Earnings shall be determined with

reference to the Eligible Employee's target amount. In the case of an Eligible Employee who is a participant in the Hewlett-Packard Company Variable Pay Plan, Earnings shall be determined with reference to the Eligible Employee's total targeted cash compensation. In no event shall compensation in excess of that amount prescribed by Section 505(b)(7) of the Internal Revenue Code of 1986 be taken into consideration for any purpose under the Plan. A Member's Earnings shall be determined on a weekly, semimonthly, monthly or annual basis as required by the Plan. The Earnings of a Member whose standard hours of employment are less than full time shall be prorated based on the standard hours of employment are less than full time shall be prorated based on the standard hours per pay period attributed to the Member relative to the standard hours per pay period of a full time employee. Such determination shall be made in the sole discretion of the Company or the Claims Administrator, as applicable. For purposes of determining benefits payable to a Member, Earnings shall be determined with reference to the Member's rate of pay as in effect on the last day the Member was actively at work (or, if later, on flexible time off or holiday) immediately preceding the onset of Total Disability; provided, however, that for the purpose of determining the benefits payable to a Member who becomes Totally Disabled while on a leave of absence or other non-paid employment status. Earnings shall be determined with reference to his or her rate of pay as in effect on the date his or her leave or nonpaid employment status commenced, except that in the case of a Member on a personal leave of absence during which he or she will engage in employment for compensation specifically approved in advance in writing by the Company, Earnings shall be the amount of such compensation.

2. Effective April 1, 1998 Section 2(f) shall be restated to read as follows:

"Eligible Employees" means an individual on the U.S. dollar payroll of a Participating Company who is engaged in regular full time employment or regular part time employment of not less than thirty (30) hours per week; provided, however, that employees who are transferred from a foreign payroll of the Company or a Subsidiary to the U.S. dollar payroll of a Participating Company shall be Eligible Employees only if they qualify for Eligible Employee Status under written guidelines adopted by the Organization (which guidelines may specify that such employees shall be considered to be Eligible Employees solely for purposes of Supplement C), except that any such classification shall not cause any person who would otherwise be eligible for coverage under Supplement C to be ineligible for such coverage.

Any individual whose wages are paid directly by a third party agency, any individual classified as an independent contractor by the Company, and any individual who is part of the Company's "flexible work force" including, but not limited to, temporary employees, freelancers, on-call employees, on-contract employees and short term employees, shall not be an Eligible Employee hereunder. Any such individual shall not be an Eligible Employee hereunder, notwithstanding that any such individual might be classified as a common law employee for any other purpose by any government agency or other entity.

An individual's status as an Eligible Employee shall be determined by the Organization, and such determination shall be conclusive and binding on all persons.

3. Effective April 1, 1998 Section 2(q) shall be restated to read as follows:

"Totally Disabled" and "Total Disability" mean that because of an injury or sickness:

(i) During the first thirty-nine (39) weeks following the onset of the injury or sickness, the Member is continuously unable to perform each and every duty of his or her Usual Occupation; and

(ii) After the initial thirty-nine (39) week period, the Member is continuously unable to perform any occupation for which he or she is or may become qualified by reason of his or her education, training or experience.

During the period described in (i) and (ii) above, a Member will not be considered Totally Disabled unless he or she is under the care of a licensed physician. "Licensed physician" means any individual described in Section 2708 of the California Unemployment Insurance Code and includes a physician, surgeon, optometrist, dentist, osteopath, chiropractor, podiatrist, qualified licensed psychologist, or for a normal pregnancy, a licensed nurse, midwife or nurse practitioner. "Under the care of a licensed physician" means (1) the Member has been regularly examined by the licensed physician at home, at the licensed physician's office or at a hospital at a frequency consistent with the Member's injury or illness and (2) the Member has received appropriate treatment for the medical condition that caused the Total Disability, both as determined by the Claims Administrator.

The determination of Total Disability shall be made by the Claims Administrator on the basis of objective medical evidence. "Objective medical evidence" shall mean that evidence establishing facts or conditions as perceived without distortion by personal feelings, prejudices or interpretations. A condition caused or contributed to by pregnancy or childbirth which results in the Total Disability of the Member shall be covered under the Plan on the same basis as other Total Disabilities. Any condition diagnosed as or, without regard to its designation is equivalent to, (1) attention deficit disorder (ADD), or (2) chronic fa-

tigue, syndrome, Epstein-Barr, Virus, or infectious mononucleosis shall be disregarded in the determination of Total Disability during the period described in (ii) above. With respect to any Total Disability caused or contributed to be mental illness or alcohol or drug abuse, the following limitation shall apply:

(A) Mental Illness

During the period described in (ii) above, in the case of a disability resulting from a nervous or mental disorder, the Member shall be considered totally Disabled only if he or she is confined to a hospital or other licensed long term care facility for the treatment of such disability or has been so confined for fourteen (14) or more consecutive days during the preceding three (3) months. An illness shall be considered a nervous or mental disorder if:

(1) The illness has psychologic or behavioral manifestations or results in impairment of mental functioning due to any causes including, but not limited to, social, psychological, genetic, chemical or biological; and

(2) The illness has a primary diagnosis that either is listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised, or falls within diagnostic codes 290 through 319 in the international Classification of Diseases, 9th Revision.

Benefits shall be payable with respect to the period described in (ii) above for no more than sixty-five (65) weeks for any disability resulting from a mental or nervous disorder. The limitations of this Paragraph (A) shall

not apply to a Total Disability due to Alzheimers disease, multiple sclerosis, amyotrophic lateral sclerosis, traumatic brain injuries, schizophrenia, or other organic, degenerative, progressive diseases as determined by the Claims Administrator.

(B) Alcoholism

In the case of a disability resulting from alcoholism, the Member shall be considered Totally Disabled only during the period described in (i) above and only while being medically treated for acute alcoholism or while a resident in an alcoholic recovery home which is approved by the California State Department of Alcohol and Drug Abuse or some other similar state regulatory agency; provided, however, that benefits shall be payable for a period of no more than thirty (30) days of residency in an alcoholic recovery home during a single period of Total Disability. Benefits shall not be payable during the period described in (ii) above with respect to a disability resulting from alcoholism.

(C) Drug Abuse

In the case of a disability resulting from drug abuse, an Eligible Employee shall be considered Totally Disabled only during the period described in (i) above and only while hospitalized for medical treatment of such disability or while the Member is participating in a medically supervised drug recovery program; provided, however, that benefits shall be payable for a period of no more than thirty (30) days of participation in such a recovery program during a single period of Total Disability. Drug abuse shall include,

but not be limited to, the taking of a prescription or controlled drug in a manner not prescribed or recommended by a licensed physician. Benefits shall not be payable during the period described in (ii) above with respect to a disability resulting from drug abuse.

4. Effective April 1, 1998 the last sentence of Section 5(b) shall be restated to read as follows:

Notwithstanding the foregoing, in the case of a Member who becomes Totally Disabled while on a personal leave of absence, no benefit shall be payable with respect to any period prior to the scheduled expiration date of the personal leave of absence, federal Family and Medical Leave Act of absence or military leave of absence.

To record the amendment of the Plan as set forth above, the Organization has caused its authorized officers to affix the Organization's name and seal hereto this 23rd day of April, 1998, effective as of the dates stated herein.

HEWLETT-PACKARD COMPANY
EMPLOYEE BENEFITS ORGANIZATION

By: /s/
Susan Bowick
President

Attest: /s/
Abraham Lev
Secretary

EXECUTION COPY

AMENDMENT TO SUPPLEMENT C TO THE HEWLETT-PACKARD COMPANY EMPLOYEE BENEFITS ORGANIZATION INCOME PROTECTION PLAN

TEMPORARY DISABILITY BENEFITS FOR CALIFORNIA EMPLOYEES (Amended and Restated as of October 1, 1994)

The following amendments to Supplement C to the Hewlett-Packard Company Employee Benefits Organization Income Protection Plan - Temporary Disability Benefits for California Employees, amended and restated as of October 1, 1994 are made by the Hewlett-Packard Company Employee Benefits Organization effective as of the dates stated herein.

1. Effective November 1, 1997 Section 2(c) shall be restated to read as follows:

> "Earnings" means an Eligible Employee's base salary or hourly rate of pay, determined without regard to any "Deferred Contributions" or "Regular Company Contributions" made on the Eligible Employee's behalf to the Hewlett-Packard Company Tax Saving Capital Accumulation Plan, and without regard to any salary reductions made on behalf of an Eligible Employee pursuant to the Hewlett-Packard Company Cafeteria Plan, the Hewlett-Packard Company Health Care Reimbursement Plan, the Hewlett-Packard Company Dependent Care Reimbursement Plan and the Hewlett-Packard Company Executive Deferred Compensation Plan. Earnings shall include flexible time off, sick leave, shift differential, vacation, jury duty, bereavement pay, holidays and other forms of paid time off, but shall exclude overtime, compensation for work in excess of the regular work week, cash profit sharing, bonuses, severance and other post termination payments and (except as provided in the following sentence) commissions. In the case of an

Eligible Employee whose compensation is determined in whole or in part on a commission or other sales related basis, Earnings shall be determined with reference to the Eligible Employee's target amount. In the case of an Eligible Employee who is a participant in the Hewlett-Packard Company Variable Pay Plan, Earnings shall be determined with reference to the Eligible Employee's total targeted cash compensation. In no event shall compensation in excess of that amount prescribed by Section 505(b)(7) of the Internal Revenue Code of 1986 be taken into consideration for any purpose under the Plan. A Member's Earnings shall be determined on a weekly, semimonthly, monthly or annual basis as required by the Plan. The Earnings of a Member whose standard hours of employment are less than full time shall be prorated based on the standard hours per pay period attributed to the Member relative to the standard hours per pay period of a full time employee. Such determination shall be made in the sole discretion of the Company or the Claims Administrator, as applicable. A Member's Earnings shall be determined with reference to the Member's rate of pay as in effect on the date he or she became Totally Disabled; provided, however, that in the case of a Member who is engaged in regular part time employment of less than thirty (30) hours a week or in temporary employment, Earnings shall be determined with reference to the wages or salary paid to such Member during the last completed calendar quarter preceding the date he or she became Totally Disabled or with reference to the wages or salary paid during the Member's highest quarter during the "disability base period" as determined under Section 2610 of the California Unemployment Insurance Code, whichever is higher; provided, further, for the purpose of determining the benefit payable to a Member who becomes Totally Disabled while on a leave of absence or other nonpaid employment status, Earnings shall be determined with

reference to the Member's rate of pay as in effect on the date his or her leave or nonpaid employment status commenced (or in the case of such a Member who was engaged in part time employment of less than thirty (30) hours a week or in temporary employment immediately prior to the commencement of his or her leave, such Earnings shall be determined with reference to the wages or salary paid to the Member during the last completed calendar quarter preceding the date his or her leave or nonpaid employment status commenced or with reference to the wages or salary paid during the Member's highest quarter during the "disability base period" as determined under Section 2610 of the California Unemployment Insurance Code, whichever is higher), except that in the case of a Member on a personal leave of absence during which he or she will engage in employment for compensation specifically approved in advance in writing by the Company, Earnings shall be the amount of such compensation.

2. Effective April 1, 1998 Section 2(f) shall be restated to read as follows:

"Totally Disabled" and "Total Disability" mean that because of injury or sickness the Member is unable to perform his or her regular or customary work. A Member will not be considered Totally Disabled unless he or she is under the care of a licensed physician. "Licensed physician" means any individual described in Section 2708 of the California Unemployment Insurance Code and includes a physician, surgeon, optometrist, dentist, osteopath, chiropractor, podiatrist, qualified licensed psychologist, and for a normal pregnancy, a licensed nurse, midwife or nurse practitioner. "Under the care of a licensed physician" means the Member has been regularly examined by the licensed physician at home, at the licensed physician's office or at a hospital at a frequency consistent with the Member's injury or illness as determined by the

Claims Administrator. The determination of Total Disability shall be made by the Claims Administrator on the basis of objective medical evidence. "Objective medical evidence" shall mean that evidence establishing facts or conditions as perceived without distortion by personal feelings, prejudices or interpretations. A condition caused or contributed to by pregnancy or childbirth which results in the Total Disability of the Member shall be covered under this Supplement C on the same basis as other Total Disabilities. In the case of a disability resulting from alcoholism, the Member shall be considered Totally Disabled only while being medically treated for acute alcoholism or while a resident in an alcoholic recovery home which is approved by the California State Department of Alcohol and Drug Abuse; provided, however, that benefits shall be payable for no more than thirty (30) days of residency in an alcoholic recovery home during a single period of Total Disability, unless the physician referring the Member to the alcoholic recovery home certifies the need for continuing residential services, in which case benefits shall be payable for an additional sixty (60) days of residency during a single period of Total Disability. In the case of a disability resulting from drug abuse, an Eligible Employee shall be considered Totally Disabled only while hospitalized for medical treatment of such disability, while participating in a medically supervised drug recovery program or while a resident in a drug free residential facility which is approved by the California State Department of Alcohol and Drug Abuse; provided, however, that benefits shall be payable for no more than thirty (30) days of participation in a medically supervised drug recovery program during a single period of Total Disability; and provided, however, that benefits shall be payable for a period of no more than forty-five (45) days of residency in a drug free residential facility during a single period of Total Disability, unless the physician referring the Member to such drug free residential fa-

cility certifies the need for continuing residential services, in which case benefits shall be payable for a period of no more than an additional forty-five (45) days of residency during a single period of Total Disability. Drug abuse shall include, but not be limited to, the taking of a prescription or controlled drug in a manner not prescribed or recommended by a licensed physician. Notwithstanding the foregoing, an individual who is ordered not to work by a written order from a State or local health officer because the individual is infected with, or suspected of being infected with, a communicable disease shall be considered to be Totally Disabled.

To record the amendment of Supplement C to the Plan as set forth above, the Organization has caused its authorized officers to affix the Organization's name and seal hereto this 23rd day of April, 1998, effective as of the dates stated herein.

HEWLETT-PACKARD COMPANY
EMPLOYEE BENEFITS ORGANIZATION

By:_____/s/_____
Susan Bowick
President

Attest:_____/s/_____
Abraham Lev
Secretary

APPENDIX K

HEWLETT-PACKARD COMPANY
INCOME PROTECTION PLAN
ADMINISTRATIVE SERVICES AGREEMENT

EXHIBIT C

HEWLETT-PACKARD COMPANY
INCOME PROTECTION PLAN
ADMINISTRATIVE SERVICES AGREEMENT

This Agreement (the "Agreement") is made by and between Voluntary Plan Administrators, Inc., 23622 Calabasas Road, Suite 250, Calabasas, California 91302-1501 (hereinafter called VPA), Hewlett-Packard Company Employee Benefits Organization (the "Organization"), and Hewlett-Packard Company (hereinafter called "Company") (collectively, the "Parties") and WITNESSETH AS FOLLOWS:

WHEREAS the Organization maintains the Hewlett-Packard Company Employee Benefits Organization Income Protection Plan (the "Plan") for its eligible Employees, a copy of which is attached as Addendum A; and

WHEREAS the Organization has requested VPA to provide Administrative Services for its said Plan, and VPA is willing and able to do so; and

WHEREAS, it is the purpose of this Agreement to establish an agency relationship whereby VPA will act as agent for the Organization in (i) receiving and processing claims for benefits under the Plan, and (ii) computing the appropriate claim payments and providing payment information electronically to the Company under the Plan, and (iii) performing such additional duties as set forth herein.

NOW, THEREFORE, in consideration of these promises and the mutual promises and agreements hereinafter contained, the Parties hereto agree as follows:

I. PLAN BENEFITS

VPA agrees to perform administration services hereunder with respect to the Plan. The Organization shall retain full responsibility for the Plan and expenses incidental thereto unless specifically assumed by VPA hereunder. Any modification or amendment of the Plan shall be duly communicated in detail and in writing by the Organization to VPA. Such com-

munication shall also set forth the effective date of the modification or amendment. Unless defined by applicable state or federal law, the date for implementation of the modification or amendment will be mutually agreed upon by the Organization and VPA and will be based on a reasonable appraisal of the effect thereof on VPA's functions and duties under the Agreement, including the effect, if any, of making additional claim payments on account of an effective date prior to the implementation date. Changes in Plan design or benefit structure which could cause VPA to be required to perform additional administrative services hereunder, can only be made by mutual written consent of the Parties hereto.

II. SERVICES PROVIDED BY VPA

A. While this Agreement remains in full force and effect, and subject to Section IX hereunder, VPA shall provide for the Organization with respect to the Plan as defined in Addendum A, the on-going Administration Services set forth in Addendum B (entitled "VPA Plan Administration Services"); Addendum C (entitled "VPA Standard Reports"), and Addendum D (entitled "Remote, On-Line Access to VPA's Computer System"), the true copies of which are attached. Furthermore, HP reserves the right to elect at any time during the Term the services described in Addendum E (entitled "VPA's Exclusive Express Claim Service (ECS)"), true copies of which are attached, and should HP exercise this right, Addendum E shall be fully incorporated into this Agreement.

B. The Organization shall establish and make all final policies, interpretations, rules, practices and procedures for its Plan, and VPA agrees to provide all services hereunder in accordance therewith. VPA shall perform only

such services with respect to the Plan as are expressly described in Addendums B, C and D and if incorporated into this Agreement by HP, those services described in Addendum E.

III. STANDARDS OF CARE

A. VPA shall perform its duties and exercise its powers under this Agreement in a professional manner, in accordance with all federal, state and local laws, regulations, licensing requirements and business statutes.

B. If it is determined that any payment was made under the Plan to an ineligible employee, due to the Organization's, Employee's or State's error or advice, or that an incorrect payment was made by VPA, due to the Organization's, Employee's or State's error or advice, VPA shall attempt to recover any such overpayment, but shall not be required to initiate court proceedings for any such recovery. If unsuccessful in their recovery effort, VPA shall promptly notify the Organization in order that the Organization may be able to take such action as may be available to it, and shall cooperate fully with the Organization in any litigation necessary to recover the overpayment.

C. If it is determined that any payment was made under the Plan to an ineligible employee solely due to VPA's error, or that an incorrect payment was made by VPA, solely due to VPA's error, VPA shall use its best efforts to attempt to recover any such overpayment or adjust any such underpayment. Under these circumstances, VPA's recovery efforts shall include, without limitation, litigation when appropriate. VPA will promptly notify the Company or the Organization if it is unsuccessful in recovering any overpayment.

D. VPA shall not be liable to the Company or the Organization or any Employee for any affirmative or negative opinion, ruling, decision or judgment relative to the qualification or entitlement of Employee to benefits, except that VPA shall be liable to the Company or the Organization for any loss, liability, damage, expense, demand, claim, lawsuit, or other cost or obligation resulting out of any dishonest, fraudulent, criminal or willful or negligent act or omission of VPA or any of its employees, officers or directors.

IV. CLAIMS REVIEW AND APPEAL OF DENIED CLAIMS

A. VPA shall have the discretionary authority to determine the extent and amount of benefits that any beneficiary may be entitled to under the Plan. VPA shall comply with the Plan Document defining the benefits as set forth by the Organization with respect to the payment and denial to beneficiaries. In the event the Organization, or the Company on behalf of the Organization, determines that VPA has misinterpreted or misapplied any of the provisions of the Plan and so notifies VPA in writing, all claims pending or reported after delivery of such notification to VPA shall be processed and paid by VPA in accordance with the instructions as set forth in such notification.

B. VPA shall comply with all provisions of the Plan contained in the sections entitled "Claims Procedure" and "Review of Denied Claims". Remedies available for the redress of claims which are denied in whole or in part shall be as comprehensive as those provided for in the Plan and shall include those procedures defined in this Section IV.

C. In the event a claim is denied by VPA, the denial shall be in writing, delivered to the claimant, and shall set forth the reasons for denial and specify the pertinent Plan provisions upon which denial is based. If additional information is necessary to process a claim, the denial shall state and/or describe any additional material or information needed to process the claim. Any denial shall also advise the claimant of the review procedure below.

1. A claimant or his/her duly authorized representative has a right to appeal denial of his/her claim to VPA. The request for review shall be made on written application. The claimant (or his/her representative) may review pertinent non privileged documents and may submit comments in writing.

2. Written application for review of denial of a claim must be received in the office of VPA not later than sixty (60) days following receipt by the claimant of the denial of his/her claim, or no appeal will be allowed.

3. VPA shall review the appeal within sixty (60) days after receipt of the appeal by VPA, unless special circumstances (such as a determination by VPA that there is a need to hold a hearing) require an extension of time for processing, in which case a decision shall be rendered as soon as possible, but in no event more than one hundred twenty (120) days after receipt of the application for review. Two weeks' notice shall be given for all hearings, unless waived.

4. In all appeal reviews, VPA shall, when appropriate, direct the claimant to obtain an independent medical examination, unless otherwise directed by the Organization.

5. The decision on review shall be in writing, and shall state the reasons for the decision, and refer to the pertinent Plan provisions upon which the decision is based, and the decision shall be final.

D. VPA will make the decision on review in conformance with procedures it has developed in the normal course of its business, and the claimant will be notified promptly and in writing of the decision. VPA shall have the discretionary authority to construe the language of the Plan and make the decision on review on behalf of the Organization. To the extent the Plan language does not address a claim or to the extent VPA is unable to construe the Plan language, VPA shall consult with the Organization prior to making a decision on review.

V. INDEMNIFICATIONS

A. VPA hereby agrees to indemnify and hold the Company and Organization, and their employees, officers and directors, harmless against any and all loss, liability, settlements, judgments, damage, expense, demand, claim, lawsuit, or other cost or obligation, including attorneys' fees, with respect to this Agreement resulting out of any dishonest, fraudulent, criminal or willful or negligent act or omission of VPA or any of its employees, officers or directors.

B. The Organization and the Company hereby agree to indemnify and hold VPA, its employees, officers and directors harmless against any and all loss, liability, settlement, judgments, damage, expense, demand, claim, lawsuit, or other cost or obligation, including attorneys' fees, with respect to this Agreement, unless such loss, liability, settlement, judgments, damages, expense, demand, claim, lawsuit, cost, obligation, arises out of, is based or results from any dishonest, fraudulent, criminal or willful or negligent act or omission of VPA or any of its employees, officers or directors, in which event it shall be covered by VPA's indemnity' obligation under Section V, Paragraph A of this Agreement.

C. The defense or prosecution of any legal action instituted on a claim for benefits under the Plan shall not be an obligation of VPA and shall be controlled by the Organization. VPA shall, however, cooperate with the Organization and Company by furnishing such evidence as it has available in connection with the defense of any such action.

VI. ORGANIZATION'S OBLIGATIONS

A. The Organization shall furnish VPA with information concerning the Plan and eligible participants thereunder as may be required by VPA to perform its services hereunder properly, including, but not limited to, employment information needed to determine eligibility for Plan benefits. The Organization shall certify the eligibility of the claimant for benefits under the Plan and the plan of benefits to which he or she is entitled. VPA shall not be liable for the non-performance or delays in the performance of this contract caused

by the Organization's failure to provide correct or timely eligibility information.

B. The Organization shall provide VPA with copies of the Organization's California Quarterly Contribution Returns (Form DE3D) and quarterly employee headcount statistics for all the other States within 45 days following the end of each calendar quarter.

C. The Organization shall provide Annual Financial Statements or post required Securities or obtain surety bonding required of self-insurers by the States of California, Hawaii, New Jersey and New York, and forward to the appropriate State Agency on a timely basis.

D. The Organization agrees that invoices for miscellaneous plan expenses as defined in Section VII, Paragraph C, that were paid by VPA, or are due VPA for special services, are due and payable within thirty (30) days of presentation of invoice to the Organization.

E. The Organization agrees that invoices forwarded by VPA for quarterly service fees are due and payable on or prior to the commencement of the period billed.

F. The organization agrees to notify VPA in writing when the Organization concludes that VPA is not interpreting the terms of the Plan as the Organization determines the Plan should be interpreted. After receipt of such notice, VPA shall review each new claim submitted in accordance with the Organization's interpretation.

G. Pursuant to the Contribution Agreement between the Company and the Organization, the Company may perform on the Organization's behalf any obligation of the Organization

hereunder. Any action taken by the Company hereunder on behalf of the Organization is in the capacity of agent for the Organization.

VII. COMPENSATION FOR VPA'S SERVICES

A. The Plan Administration Fee charged by VPA hereunder is based upon the Plan design in Addendum A and the services described in Addendums B, C, and D. Should the Organization or the Company exercise its right to contract for services described in Addendums, the Parties agree to be bound to the fee structure set forth therein.

B. In consideration of the aforementioned services provided by VPA, the Organization agrees to pay VPA in accordance with the fee schedule contained in Addendum F, a true copy of which is attached.

C. VPA's Plan Administration Fee covers all VPA expenses of administering the Organization's Plan, as set forth in Addendum A of this Agreement, and Addendums B, C and D, except for the following "Other Plan Expenses" which will be paid directly by VPA. On a monthly or semi-monthly basis, VPA will itemize expenses paid by it and will invoice the Organization therefor. The Organization agrees these invoices are due and payable within thirty (30) days of receipt of such invoice.

1. ***Printing Expenses***

   Typesetting and printing expenses for ECS I.D. Cards and ***any other special forms unique to the Organization's Plan***. VPA will secure printing approval from the Organization before committing to these expenses.

2. ***Closed Claim Storage Expenses***

Monthly expenses for commercial storage, retrieval and return of closed claim files will be submitted to the Organization each month.

3. ***Claim Investigation Expenses***

Costs of outside services provided by parties other than VPA, such as medical consultations, conducting Independent Medical Examinations, conducting field investigations or surveillances, copying doctors' or hospital records, etc., which are required in the day-to-day administration of the Plan claims. VPA will provide the Organization with substantiation of all expenses. VPA will secure approval from the Organization before committing to new methods of claim investigation which result in additional Plan expenses.

4. ***Outside Rehabilitation Services***

Costs of outside rehabilitation services such as claimant evaluated by a Vocational Rehabilitation Nurse and/or evaluation training or treatment at a Rehabilitation Center or hospital are the responsibility of the Plan or the Organization. VPA will secure Organization approval of these expenses before incurring the expense.

5. ***Travel Expenses***

If VPA personnel are required or requested to visit the Company, a claimant or to attend an appeals hearing and the destination is greater than 75 miles

from the applicable VPA employee's office, VPA will be reimbursed from the Plan for the following expenses:

a. Actual public transportation expenses.

b. Actual meals and lodging expenses.

c. Automobile mileage at $.29 per mile.

Such reimbursable travel of VPA personnel must have been approved, in advance, by the organization to be reimbursable to VPA.

6. ***Communications Expenses***

Expenses for maintaining a dedicated toll-free 800 number, dedicated FAX numbers or a dedicated E-Mail number, a dedicated remote access modem line and a dedicated line for interface with the Workers' Compensation Administrator's on-line systems at VPA's office will be the responsibility of the Organization. The Organization will be invoiced monthly for these expenses.

7. ***Special Reports or Program Modifications***

Requests for specialized reports that are not part of the standard reports provided under the terms of this Agreement or Special Report Formats or special program modifications are provided upon request for a fee of $80.00 per hour (1 hour minimum) for systems analysis, programming and

testing time, the actual cost for additional software that might be needed and a handling fee of $50.00 per special report produced plus the cost of tape or diskette and/or the telephone line charge for the phone line used for the electronic transfer. Software written for the Company and paid for by the Organization, is the property of the Company and may not be used, in whole, for any other VPA client without the consent of the Company.

8. ***"Express Claim Service (ECS)" Expenses***

At the Organization's option, VPA will provide their exclusive ECS (no claim form) claim processing system (See Addendum E for details) for the fees and expenses outlined in Addendum E. These expenses will be invoiced to the Organization at the end of each month.

D. If a revision in the Annual Plan Administration Fee is deemed necessary by VPA by reason of the modification or amendment of the Plan or VPA's services for the Organization, VPA shall, within sixty (60) days after receipt of a copy of such request for modification or amendment to the Plan or VPA's services from the Organization, advise the Organization of a revised Plan Administration Fee and a proposed effective date. Within sixty (60) days after receipt of notice of the proposed revised Plan Administration Fee from VPA, the Organization will notify VPA of the acceptance or non-acceptance of the revised fee. If the revised fee is not acceptable, such written notice shall constitute a termination of the Agreement effective as of midnight of the last

day of the month following the month in which VPA receives such notice. However, Plan administration services provided by VPA on and after the proposed modification effective date, shall be compensated for such services based on the proposed, revised Plan Administration Fee.

The Organization shall furnish VPA with a copy of each modification or amendment of the Plan or VPA's services as soon as is practicable and in advance of the effective date of such modification or amendment, if possible. After receipt by VPA of a copy of the modification or amendment the term "Plan" as used in the Agreement shall include each such modification or amendment as of the effective date agreed upon by the Parties hereto.

VIII. AGREEMENT TERM AND EFFECTIVE DATE

A. The term of this Agreement shall be for twelve (12) months commencing at 12:01 a.m. on January 1, 1995.

B. At the end of the term of this Agreement, this Agreement shall be renewed automatically, unless terminated pursuant to Section IX hereunder, for successive terms of three (3) months each.

IX. TERMINATION OF AGREEMENT

A. Either party may terminate this Agreement, with or without cause, at the end of each contract term by giving the other party at least ninety (90) days prior written notice.

B. However, this Agreement shall terminate immediately upon:

1. The date either party or its representatives are unable to continue to perform

under the terms and conditions of this Agreement due to the voluntary or involuntary bankruptcy of either of the parties.

2. The effective date of any new law whose terms prohibit or are interpreted to prohibit the continuance of this Agreement, or will cause or are interpreted to cause a penalty to either party for continuing this Agreement.

3. The effective date of the termination of the Organization's Plan and the return of all of the Organization's employees to the State Disability Insurance (SDI) Plan coverage. (Note: Individual Plans may be terminated or added to this Agreement without any effect on the terms of this Agreement).

C. The Company or the Organization may terminate this Agreement immediately if VPA, after 60 days written notice of its failure to perform hereunder, is unable or fails to cure such performance.

D. The Company or the Organization may terminate this Agreement pursuant to subparagraph D of Section VII herein.

E. In the event of termination of the Organization's Plan, VPA shall complete at the request of the Organization the processing of all claims for benefits under the Plan which were incurred prior to termination. VPA shall be reimbursed for the administration of such claims on a prorata basis of the Quarterly Plan Administration Fee then in effect but subject to a minimum monthly fee of $2,500 per month.

F. No later than the effective date of termination of this Agreement, VPA shall surrender to the Organization all hard copy claims records associated with the Plan.

G. Upon the effective date of the termination of this Agreement by any party, all services provided by VPA to the Plan will cease and nothing in this Agreement can be construed to require any further services to be provided by VPA.

H. Upon termination, all computerized claimant records (on-line and on magnetic tape) for the Company's claims and payments, and a detailed explanation of record format shall be delivered to the Organization. If the Organization requests a specific format, such formatting will be subject to the same terms and conditions expressed in Section VII, Paragraph 7. VPA also agrees to purge its system of all Company claims and payment data upon completion of the above specified reports.

X. STATUS UNDER EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (AS AMENDED) (ERISA) AND STATE LAWS.

A. The Parties understand and acknowledge that, although VPA is providing administrative services with respect to the Plan, the Organization, and not VPA, shall be deemed the Plan Administrator, with full responsibility for compliance with ERISA, applicable State law and other governmental reporting and disclosure requirements.

B. The Organization understands and acknowledges that it, and not VPA, shall be the "named fiduciary" under ERISA with respect to the Plan.

C. It is the intent, desire and understanding of the parties that nothing in this Agreement shall make, or be construed to make VPA a fiduciary (as that term is defined under ERISA) of the Plan.

XI. RELATIONSHIP OF PARTIES

VPA in performing its obligations under this Agreement is an agent of the Company and the Organization. VPA shall not be deemed to be an employee of the Company or the Organization for purposes of any employee benefit program, income tax withholding, unemployment benefits, disability benefits, employment taxes or otherwise. Except to the limited extent expressly authorized by the Agreement, VPA shall not have any authority to enter into any agreement, incur any obligation or act for or on behalf of the Organization or to bind or commit the Organization to any obligation or in any other manner.

XII. DEFENSE OF SUITS

A. In accordance with ERISA and State Disability Plan Regulations, there are prescribed appeal processes regarding benefits denials that must be pursued by a Plan claimant including those processes set forth in Section IV. All VPA administrative expenses (except those Other Plan Expenses noted in Section VII) involved in VPA's handling of the claimant's appeal are the responsibility of VPA.

B. However, should a claimant initiate litigation against the Plan, the Company, the Organization, and/or VPA, then the Organization or Company shall retain, direct, and control legal counsel. VPA shall cooperate with the Organization by furnishing such evidence it has available, including testimony of VPA personnel, if necessary.

C. All litigation costs and legal fees incurred by the Plan, the Company, the Organization, and/or VPA shall be paid by the Company. Any compromise, settlement, or judgment, will be paid by the Company unless paid by the Plan (to the extent permitted by federal law), except to the extent that the compromise, settlement or judgment is covered by VPA's indemnity obligation under Section V, in which case it shall be paid by VPA.

D. It is understood that in the best interests of the Plan, neither VPA nor the Organization or Company should enter into any compromise or settlement of any legal proceedings, in which VPA and the Organization or Company are joined without prior consultation with each other. If, however, a disagreement arises between Organization or Company and VPA as to the advisability or terms of such settlement, Organization's or Company's determination shall be final.

XIII. RECORDS

A. The Organization shall be the owner of records relating to claims for benefits under the Plan, but VPA shall maintain such records and, until the termination of this Agreement, have continued access to such records to enable VPA to comply with regulatory requirements and standards. Any duly authorized representative of the Organization shall have the right to examine or audit records during VPA's regular business hours, upon five (5) days written notice to VPA.

B. Recordkeeping shall be carried out in accordance with prevailing Internal Revenue Service, ERISA and Insurance Industry standards, however, VPA shall not dispose of any

records delivered by the Organization, without the prior written approval of the Organization. In no event shall records be retained for less than seven (7) years.

C. VPA shall retain Monthly Check Register and Monthly Claims Activity Data, in an on-line status on VPA's computer system, for a minimum of 18 months from the current date.

D. VPA shall take reasonable and prudent steps to secure and safeguard Plan records, which includes maintaining an armed response security and fire alarm system in all VPA offices.

E. All information and records which are compiled by, obtained by or furnished to VPA under this Agreement are acknowledged and understood to be confidential information and records and the exclusive property of the Organization. During and after the term of this Agreement, VPA agrees that it will not, directly or indirectly, divulge in any manner, or use or permit others to use any of this information or records, except to the limited extent necessary to perform VPA's services.

XIV. COMMUNICATIONS

A. Any Party shall be entitled to rely upon any communication received from the other Parties which any Party reasonably believes to be genuine and to have been executed or presented by the proper Party or Parties.

B. None of the Parties shall be bound by any notice, direction or request unless it has been received in writing.

C. Any notice sent pursuant to this Agreement shall be in writing and sent to Organization and Company as follows:

Nancy LaMarca
Benefits Systems and Administration Manager
Corporate Benefits
Hewlett-Packard Company
3000 Hanover St., M/S 20AE
Palo Alto, CA 94304

D. Any notice sent pursuant to this Agreement shall be in writing and sent to VPA as follows:

Jack H. Bredehorn, President
Voluntary Plan Administrators, Inc.
23622 Calabasas Road, Suite 250
Calabasas, California 91302-1501

E. Each Party shall have the right to change the person designated to receive notices upon written notice to the other Party.

F. Notices shall be sent by United States certified mail, return receipt requested, postage prepaid; hand-delivered; telefaxed; or by reputable private delivery service with proof of delivery.

XV. INSURANCE COVERAGES

A. VPA agrees to maintain a minimum $1,000,000 liability policy which is a combined single limit policy.

B. VPA agrees to maintain a minimum umbrella policy with a combined single limit of liability in the amount of $2,000,000.

C. VPA agrees to maintain a minimum $1,000,000 Fidelity Bond covering all employees including officers.

D. VPA agrees to maintain a minimum $1,000,000 Errors and Omissions Policy.

E. VPA agrees to maintain a minimum automobile liability policy with a combined single limit of $1,000,000 which includes owned and non-owned automobiles.

F. VPA agrees to maintain Workers' Compensation coverage to comply with all statutory regulations of the State of California.

G. Upon written request from the Organization, VPA will evidence the required coverages in A through F above, by providing the Organization with a copy of the Insurance Certificate from the issuing insurance companies or a statement of coverage from VPA's Broker.

XVI. ASSIGNMENT AND DELEGATION

A. No assignment of rights or delegation of duties hereunder by either party shall be valid unless the prior written consent of the other party shall first have been obtained. Provided, however, that VPA grants to the Organization or Company the right to assign this Agreement and all rights granted to the Organization or Company under this Agreement to any party acquiring a substantial portion of the business of the Organization or Company, and upon any such assignment and the assumption of this Agreement by the assignee, the Organization and the Company shall have no further rights or liability under this Agreement.

B. VPA may delegate its duties hereunder wholly or in part to any organization or person, provided that, notwithstanding any subcontract or delegation, VPA shall remain responsible for its obligations under this Agreement. The Organization shall be given prior written notice of any work to be performed through such subcontractor or delegate. Any such organiza-

tion or person shall be subject to the same terms and conditions as VPA hereunder.

XVII. AUDIT

The Company and the Organization shall have the right at reasonable times and with reasonable notice, to inspect any eligibility and benefit payment records of VPA which are directly relevant to any aspect of this Agreement. VPA agrees to provide the Company, the Organization, and/or their duly authorized representatives reasonable access to the Organization's data in the VPA hard copy files or in the VPA DCMS which is necessary to audit the Organization's claims and benefit calculation process.

XVIII. PUBLICITY

VPA shall not orally or in writing refer to the Company or the Organization in furtherance of its business or marketing efforts, without the express written consent of the Company or the Organization.

XIX. NON-DISCLOSURE OF COMPANY OR ORGANIZATION INFORMATION

VPA shall not disclose any Company or Organization information—including but not limited to information relating to employees, records, reports systems, benefit plans, methods of claims review and appeals of denied claims, banking arrangements, compensation for VPA's services, and the like—without the express prior written consent of the Company.

XX. ENTIRE AGREEMENT AND AMENDMENT

A. This Agreement constitutes the entire Agreement of the Parties and may be modified or amended only by a writing signed by the Parties. Such modification or amendment shall thereupon be attached to and become a part of this Agreement.

B. This Agreement may be signed in one or more counterpart copies, each of which shall be deemed an original copy, and all of which together shall constitute one and the same Agreement.

C. It is understood that this Agreement is not intended, and shall not be construed, to require VPA to provide services of a type or to a degree not expressly described herein.

D. It is understood and agreed that VPA will not perform, and the Organization will not request performance of, any services which may constitute the practice of law.

E. This Agreement shall be governed by, and shall be construed with, ERISA and, to the extent that state law is not preempted by ERISA, the law of the State of California.

IN WITNESS WHEREOF the parties hereto have executed this Agreement at the places and on the dates specified below.

VOLUNTARY PLAN ADMINISTRATORS, INC.

Place: Calabasas, California By: /s/
Jack H. Bredehorn
Date: 2-8-95 Title: President

HEWLETT-PACKARD COMPANY

Place: Palo Alto, California By: /s/
D. Craig Nordlund
Date: FEB 16 1995 Title: Associate General Counsel & Secretary

HEWLETT-PACKARD
COMPANY
EMPLOYEE BENEFITS
ORGANIZATION

Place: Palo Alto, California

Date: _____

By: /s/
Pete Peterson

Title: Vice President, Personnel

ADDENDUM A

PLAN DOCUMENT AND/OR SUMMARY PLAN DESCRIPTION

This Administrative Services Agreement covers the following Plan Documents:

Hewlett-Packard Company Employee Benefits Organization Income Protection Plan.

Supplement A	Temporary Disability Benefits for New York Employees.
Supplement B	The Hewlett-Packard Company Employee Benefits Organization Private Plan of Temporary Disability Benefits for New Jersey Employees.
Supplement C	Temporary Disability Benefits for California Employees.

ADDENDUM B

HEWLETT-PACKARD COMPANY
INCOME PROTECTION PLAN
ADMINISTRATIVE SERVICES AGREEMENT
VPA PLAN ADMINISTRATION SERVICES

Dedicated Service Team

- VPA will establish and maintain a Dedicated Service Team that is supported by the VPA management and their technical staffs. The Dedicated Service Team at a minimum will include a Team Leader, three Disability Benefit Specialists, supporting staff of Claim Service Representatives and Mail Clerks. The Team will have their own direct telephone answering system, fax machines and personal computers for electronic mail and access to the Hewlett-Packard Workers' Compensation Administrator's data base. VPA will notify the Organization of any changes in the Dedicated Service Team.

Receive, Review And Evaluate Each Claim

- The Company managers or their designee initiate the claim process by sending the Notification of Disability form to the Company's Disability Service Center (DSC). The DSC electronically transmits to VPA the claim notice and mails a claim packet to the employee.
- VPA keeps the manager advised by automatic Hewlett-Packard Desk Messages when the claim is approved and when there is an extension of the *Return to Work Date* or a termination of the claim.
- The *Employee Claim Form* and the *Attending Physician's Statement of Disability* are mailed to the employee by the DSC and received by VPA after completion by mail or fax. A claim folder is prepared when the first of the following is entered to the DCMS system: The
- Employer's Notice, the Employee's Claim Form or the Attending Physician's Statement. These items are entered in

VPA's Disability Claims Management System (DCMS) within one business day.

- Upon receipt of the claim folder, the VPA Disability Benefit Specialist (DBS) determines if any essential information is missing and requests the missing data, if necessary. Determination will be made within three to five business days.
- When the Doctor's estimated Return to Work date and the Diagnosis Code (ICD-9 Code) given by the Physician is entered into the VPA DCMS, the VPA DCMS automatically checks the approved VPA "Disability Duration Yardsticks" (normal average duration per Disability Diagnosis) for that diagnosis code against the duration of disability approved by the Doctor. If the Doctor's approved duration exceeds the Disability Duration Yardsticks, for that Diagnosis Code, the VPA DBS contacts the Doctor and asks the Doctor to document the reasons for the variation and to send the justification to VPA for review. Also, if the Doctor's diagnosis is too vague to determine whether an objective disability exists, the DBS will question the diagnosis and request additional information (i.e., Request the Doctor's office to send a copy of the patient's records).
- When the employee faxes or mails the Employee's Notice of Claim, he or she also indicates if integration of FTO with the disability benefit is requested. The FTO election is later electronically transmitted to Hewlett-Packard Payroll as part of the DIB file.
- The DSC provides VPA with all information necessary to prove that the claimant is eligible for coverage under the Plan. This information is sent electronically by the DSC as part of the *Employer Notice of Claim.*

When appropriate, VPA will take the following actions.

- Procure additional information as needed by corresponding with the claimants, physicians and hospitals. (Copies of all such correspondence would be provided to the Organization, if requested).

- Advise and aid claimants in meeting requirements for additional information and proper completion of claim forms and submission of requests for a review of the initial decisions.
- Schedule Independent Medical Examinations and field investigations of claimant activities as required to control claim abuses.
- Perform claim investigations as necessary and review claims, when necessary, with local medical consultants.
- Request copy of Social Security-Disability Application and a Promise to Repay from claimant after 120 days of disability. (Claimant must provide VPA with evidence of having filed for Social Security Disability benefits and sign a Promise to Repay or VPA will deduct an estimated Social Security benefit from benefit payments).
- Encourage claimants who are declined Social Security Disability benefits to appeal the denial when appropriate. Follow-up semi-annually with all denied claimants.
- Annually review for Social Security payment amounts and dependent coverage.
- Investigate possible Third-Party Integration, or "no-fault" Auto Insurance Integration and obtain a Reimbursement Agreement prior to releasing payments.
- Discuss claims, where applicable, with physicians and other providers of services.

Authorization of Benefit Payments and Payment of Expenses For The Plan

VPA will:

- Apply claims control procedures necessary to the effective implementation of the basic principle of the Plan, including, but not limited to, the coordination of benefits from other sources to avoid duplication.
- Determine benefit offsets available (i.e., Estimated or Actual Social Security Benefits, State TDI Benefits, Workers'

Compensation, Third Party recovery, etc.), and adjust gross benefit payable for such offset.

- Upon approval of the claim by the DBS, the benefits are computed by the VPA DCMS Computer System in accordance with the Plan Document.
- Submit a claim to the Organization, on a monthly basis, for reimbursement of "Other Plan Expenses". Other Plan Expenses include, but are not limited to, all costs incurred on behalf of the Organization or the Plan such as cost for claim forms, Organization Notices, Plan
- Documents, etc., and all costs which are specifically related to an individual claim in the nature of fees, expenses and costs of. independent investigations; copying transcripts, medical and hospital records; consultative medical reviews, examinations and/or records and any other items which are deemed necessary to properly carry out the responsibilities that are delegated to VPA by the Organization. Other Plan Expenses do not include services performed by employees of "VPA".
- Continue periodic authorization of payment on open claims until benefit entitlement ceases.

Denials

- Consistent with Section IV of this Agreement, VPA will communicate to claimant the fact of and reason for denial of benefits and the claimant's right to review and, when requested, send a copy to the designated departments of the Company and the Organization.

Rehabilitation

- VPA will identify rehabilitation candidates and coordinate rehabilitation efforts with Company and outside agencies.
- Vocational rehabilitation will be promoted in cases mutually agreed upon by VPA and the Company.

- Where an employee has been approved for a rehabilitation work schedule, VPA will calculate the benefit payable based on Plan provisions.
- Once per semi-monthly pay period VPA runs an internal rehab hours report (displays active claims which have rehab hours present). This report is used by VPA examiners to double check that the rehab hours are up-to-date.

Overpayments

- For all overpayments of $50 or greater the employee will be notified in writing as to the amount of the overpayment including the calculations to support that they were paid an amount greater than benefits.
- The overpayment will be collected as either an offset to future benefits, a negative adjustment collected by the Company's payroll process or a direct payment from the employee.
- If the overpayment is greater than $1,000, VPA will follow up with the estate of a deceased employee.
- If the standard requests are unsuccessful in recovering an overpayment of greater than $1,000 on a claim for a terminated employee, VPA will pursue through collections.
- VPA will submit a monthly overpayment report to the Company's Payroll Services Center.

Workers' Compensation (WC)

- The Company will notify VPA when there is an approved Workers' Compensation claim by an electronic mail message.
- VPA will accurately determine and offset Workers' Compensation benefits based on the information provided in the WC administrator's data base.
- VPA will not initiate any additional claims investigation such as an IME or surveillance on a WC claim without prior discussion with the claims specialist managing that WC claim.

- VPA will request a "promise to Repay" from any employee when there is a question of a WC claim (if the employee, manager, or treating physician indicate a work related claim).

State Disability Insurance Regulations

- Provide claimant with full disclosure of any State Disability Insurance Laws regarding denial or reduction of benefits.

Archives

- All claim records and claim files are the property of the Company. VPA will retain all closed files in accordance with applicable State and Federal Records retention requirements or the Company requirements, whichever are greater. Note: Whenever a nervous or mental condition is involved, VPA usually advises the Company to retain those files indefinitely.

Standard Reports

- See Addendum C, entitled "VPA Standard Reports".

Miscellaneous

- Performance on a sample basis of internal audits on claim payments to verify the timeliness and accuracy of payments, adequacy of Proof of Claim, eligibility of claimants for benefits, and the accuracy and completeness of the data entry process. Provide reports of these findings to the Company.
- Available upon request, will be our assistance in Plan Design, Funding options and providing data for the establishment of Plan Reserves.
- Monitoring of two dedicated FAX machines used for the receipt of Employee Claim Forms, Attending Physician's Statements of Disability forms, Extensions of Disability forms, etc. to save the mail time otherwise experienced. Once received, the FAX messages are processed with the same priority as other documents received through the mail which is distributed within two hours of receipt and the data

entered into VPA's computer data base within one business day of receipt.

- VPA will process all new claims within five (5) work days of receipt of all necessary data (Employee Statement, Doctor's Statement, and Employer Notice information). If claim is delayed (not authorized for payment) within 5 work days, the claimant will be notified by phone or mail.
- Notification to Company prior to implementing any changes to VPA's claims administration system applicable to the Plan, including, but not limited to, instruction to claims offices, new or modified forms and other documentation, claims valuation, review processes, all staffing changes in the Company's unit, management or data processing department and new office locations.
- Cooperate in exploring and implementing various managed care alternatives in order to enhance administration of services.
- Produce and send an Employee Questionnaire to all closed claimants (with a paid return address envelope that is paid for by the Organization) requesting their opinion and thoughts on how the disability benefit processing system worked for them. Research any negative comments regarding VPA's services and determine what corrective action is needed, if any to eliminate similar complaints in the future. Compile a quarterly report on the results from the questionnaires and forward to the Company's Benefits Department with VPA's comments and the VPA action plan for improving customer satisfaction.

ADDENDUM C
HEWLETT-PACKARD COMPANY
INCOME PROTECTION PLAN
ADMINISTRATIVE SERVICES AGREEMENT
VPA STANDARD REPORTS

The following list includes the reports or information that are provided by VPA as standard reports:

A. NEEDED BY PAYROLL DEPARTMENT

1. Electronic transmittal of disability payment information each semi-monthly pay period.
2. Monthly report of claims paid transmitted in a file form that includes claimant name, social security number, employee number, entity, gross benefit, offsets and adjusted gross benefit.
3. Monthly reconciliation of the semi-monthly voucher files to the monthly register of payments authorized.
4. Monthly Refund Report.
5. Monthly Overpayment Report sorted by entity.

B. NEEDED BY BENEFITS DEPARTMENT

1. Monthly Short-Term Disability Claims Activity Report (Summary only).
2. New Claims Summary by diagnosis code and sex (quarterly and annual totals).
3. Claim costs by diagnosis code (quarterly and annual totals).
4. New claims by seniority (quarterly and annual totals).
5. Monthly Long-Term Disability Claims Activity Report (Summary only).
6. Quarterly Questionnaire Summary.
7. Unformatted Data tape or diskette (on request only) to support special-benefit projects.

C. NEEDED BY EMPLOYEE BENEFITS ACCOUNTING

1. ***Needed Monthly:***

   a. A Monthly Register of payments authorized in the month which matches the electronic payment data provided to the Company by VPA during that month.

   b. Monthly General Ledger Posting Report—Payment Register.

   c. Annual Claims Rate/Duration Analysis for each plan—Short-Term Disability California, Short-Term Disability Non-California, and Long-Term Disability.

2. ***Needed By Plan Year End For Actuarial Purposes:***

   a. Long-Term Disability census should include name, gender, date of birth, date of disability, and monthly benefit amount.

   b. Number of open short-term disability claims as of a specified date and average weekly benefit on those open short-term disability claims.

   c. Average duration of short-term disability claims closed in a specified three month period.

   d. Average period of delay from date of disability to date first pended—base this statistic upon claims which had their first payment within the contract period.

3. ***Needed For Quarterly State Reporting:***

   a. Produce state-mandated quarterly reports for California Voluntary Plan and New Jersey Private Plan and furnish the Company with timely copies thereof.

4. ***Needed For Annual State Reporting:***

   a. New Jersey
      Total gross amount of temporary disability paid during the calendar year to claimants who worked in New Jersey.

   b. New York
      (1) Benefits and Claims (Total); All Claims and Coverage (including Pregnancy Related Disabilities) broken down by Statutory Coverage, Plan Coverage, and Total.
         a. Number of initial indemnity claims allowed.
         b. Number of weeks for which indemnity benefits were paid.
         c. Amount of indemnity paid.

      (2) Benefits and Claims (Pregnancy Related Only).
         Disabilities caused by or in connection with pregnancy only broken down by Statutory Coverage, Plan Coverage and Total.
         a. Number of initial indemnity claims allowed.
         b. Number of weeks for which indemnity benefits were paid.
         c. Amount of indemnity paid.

   c. Hawaii
      (1) Amount of benefits paid in the year to male employees.
      (2) Number of different male employees paid disability benefits during the year.
      (3) Number of weeks for which benefits were paid to male employees. (Number should be to the nearest tenth of a week, i.e., 6 weeks = 6.0.)
      (4) Number of separate periods of disability for which benefits were paid to male employees.

(5) Total number of claims denied to male employees.
(6) Amount of benefits paid in the year to female employees.
(7) Number of different female employees paid disability benefits during the year.
(8) Number of weeks for which benefits were paid to female employees. (Number should be to nearest tenth of a week, i.e., 6 weeks = 6.0.)
(9) Total number of claims denied to female employees.
(10) Amount of subrogation payments received during year.

5. ***Unique reports requested:***

See Section VII, Paragraph C, 7.

ADDENDUM D

HEWLETT-PACKARD COMPANY
INCOME PROTECTION PLAN
ADMINISTRATIVE SERVICES AGREEMENT

REMOTE, ON-LINE ACCESS
TO VPA'S COMPUTER SYSTEM

PURPOSE:

To provide remote, on-line access to the "Claims Inquiry" screens for the Organization and the Company. This remote access eliminates the necessity for the Organization to call VPA for claim status information and other related claimant information.

PROCEDURE:

In order to provide each user with remote en-line access to VPA's proprietary "Disability Claims Management System (DCMS)", VPA programmers have to complete the following steps:

- Create a unique Password and log-in account number exclusively for each users use.
- Create a special menu to list the specific screens the Organization can call up for view (including controls to limit the Organization's access to their data only).
- Add edits to the system to prevent Organization's personnel from changing data on these screens.
- Allocate a dedicated port on VPA's computer system and allocate sufficient memory for support of each user.

ON-GOING ORGANIZATION EXPENSES FOR REMOTE ACCESS:

- The monthly telephone charges for the telephone lines used to communicate between the modems.
- A computer CPU use charge of $20 per minute or fraction thereof. There is no charge for system access or for viewing inquiry screens and only small charges for re-

trieving and entering data (e.g., 3-4 hours of access time could equal less than 1 minute CPU time/day).

- System support, retraining, or reprogramming charges at the rate of $80 per hour.
- A one-time charge of $1,000.00 for an additional dedicated port on VPA's DEC computer for each additional user.
- A one-time charge of $1,000.00 for allocation of additional Internal memory to support each new remote user.

BILLING PROCEDURE:

- A monthly invoice for remote access charges are sent, at the end of each month, to the Employee Benefits accounting office of the Organization.

ADDENDUM E

VPA'S EXCLUSIVE

EXPRESS CLAIM SERVICE (ECS)

PURPOSE:

To *eliminate claim form handling and processing* for the *Employer* and the *Employee.* ECS is specifically designed to *eliminate* the typical *delay of* 3-4 weeks, or more, required for a disabled employee to receive a Claim Form from their employer, complete the Employee Information section, take or send the Claim Form to their Doctor, have the Doctor complete the Physician's Statement, and have the Doctor's office mail the completed Claim Form to the Employer or the Claims Administrator.

PROCEDURE:

- The client pays for VPA to establish and operate a dedicated 800 telephone line for their claimants.
- Employees are provided a Disability Benefit I.D. Card (See Enclosure 1).
- Disabled Employees are informed on the Disability Benefits I.D. Card to call the 800 number to notify VPA of their disability and to have their Doctor call VPA on the same 800 number.
- A VPA Claims Service Representative (CSR) takes the Employee information (See Enclosure 2) over the phone and enters the information directly into the VPA "Disability Claims Management System" (DCMS).
- Upon receipt and entry of the Employee claim information, the DCMS automatically produces an "Employee/Physician Statement of Eligibility for Disability Benefits" Form (See Enclosure 3) which is sent to the Employee immediately. (**NOTE**: This form includes a "Physician's Certificate" that

can be completed and FAXED or sent to VPA in lieu of the Doctor's office calling VPA on the 800 number).

- When the Doctor's office calls VPA with the Physician's Claim information, the VPA Claims Service Representative (CSR) takes the call and enters the Doctor's estimated Return to Work date and the Diagnosis Code (ICD-9 Code) given by the Physician into the VPA DCMS. The VPA DCMS automatically checks the approved "Disability Duration Yardsticks" (Established average duration per Disability Diagnosis as recommended by the California and Minnesota Medical Associations) for that diagnosis code against the duration of disability approved by the Doctor. If the Doctor's approved duration exceeds the Disability Duration Yardsticks, for that Diagnosis Code, the VPA Claims Service Representative verbally requests the reasons for the variation, asks the Doctor to document the reasons for the variation and to send the justification to VPA for review. Also, if the Doctor's diagnosis is too vague to determine an objective disability exists, the CSR will question the diagnosis and request more objective findings (i.e. Request the Doctors office to send a copy of the patients' records).

- Upon completion of the phone call from the Physician's office, the CSR immediately calls the Doctors office telephone number to validate that we were actually talking to a Doctor's office.

- Upon receipt of the phone call from the Employee or the Doctor, the VPA DCMS automatically produces an "Employer's Notice of Claim" Form (See Enclosure 4) which is then FAXED to the Employer with instructions to complete the form and return it to VPA by FAX.

  NOTE: For those Employers who have elected to utilize VPA's remote computer access ser-

vice, this request will be displayed on their terminal screen when they access the "Employer's Notice" section of the on-line access menu. They can then enter the data directly into the VPA computer Data Base.

- Upon receipt of the completed "Employer's Notice of Claim" Form from the Employer, the VPA CSR enters the information into the DCMS, creates a claim file for the claimant and forwards the file to the VPA Claims Examiner.

- The VPA Claims Examiner reviews the Employee information, the Doctor's information and the Employer's Notice information on the DCMS. If everything is in order, the claim is approved for payment on the DCMS, which calculates and prints the first benefit payment check immediately. The DCMS then sets up the claim to be paid every other week, or semi-monthly (client preference) thereafter until the Employee's scheduled Return to Work Date. In order for the claimant to receive each subsequent benefit payment check, (after the first), he or she must return the "Claim for Continuing Benefits" Form (See Enclosure 5) which is attached to each first and/or continuing benefit payment check.

- With the next to last benefit payment check and the last payment check, the claimant is sent a "Physician's Supplemental Certificate" Form (See Enclosure 6) for his or her use if an extension is necessary.

- Upon receipt of any disability extensions from the Doctor, the VPA Claims Examiner reviews the supplemental information to determine whether or not to approve the extension. If the extension is not approved, a denial letter is sent to the Employee (carbon copy to the Employer) explaining the reason for the denial and explaining the appeal rights for the Employee.

- Each week, VPA sends the client a "Weekly Claims Activity Report" to notify the client of claims processing activity for that week.

ADDITIONAL COSTS FOR ECS:

- The cost of the dedicated 800 number.
- A VPA surcharge of $25.00 per claim received on the 800 number.
- The cost of printing the ECS cards for the Employees.

ADVANTAGES OF ECS:

- Elimination of claim form handling and mailing for both Employer and Employee.
- Elimination of claims processing delays (1-2 weeks versus 3-4 weeks).
- Reduction in client's internal benefits administration costs. (No mailing of Claim Forms, fewer calls from claimants who haven't received their benefits, etc.).
- Improved Employee relations from faster benefit payments and easier claim processing.
- Faster, easier and less expensive for Doctors to process Disability Benefit claims. Decreased claims duration of up to 25% per claim.

SHORT-TERM DISABILITY BENEFIT I.D. CARD

XYZ CORPORATION
Short-Term Disability Benefits Administered By:
Voluntary Plan Administrators, Inc. (VPA)

If you are or will be hospitalized or if you have been or will be absent from work for more than 5 consecutive work days due to your disability (on-the-job or off-the-job), first call your supervisor and then call the following number. Monday through Friday 8:30 a.m. to 4:45 p.m., to apply for your short-term disability benefits.
Please present this card to your attending physician at the time of your examination and have them follow the instructions on the reverse side.

1-800-000-000

FRONT

INSTRUCTIONS FOR ATTENDING PHYSICIAN

URGENT: YOUR PATIENT'S INCOME CONTINUATION DEPENDS ON YOU CALLING VPA IMMEDIATELY AT 1-800-000-000 TO CERTIFY HIS/HER PERIOD OF DISABILITY.
PLEASE CALL VPA WITH THE FOLLOWING INFORMATION
● DIAGNOSIS ● ICD9 CODE ● FIRST DAY DISABLED
● EXPECTED RETURN TO WORK DATE ● OTHER INFORMATION

Please make a copy of the employee's authorization for your records.

I hereby authorize my attending physician to furnish to VPA all facts concerning my medical condition for the purpose of determining my eligibility for disability benefits

_____ EMPLOYEE SIGNATURE

___/___/___ DATE SIGNED

FRONT

EMPLOYEE INFORMATION
REQUESTED OVER THE PHONE

EMPLOYEES STATEMENT

IMPORTANT: Social Security No. ____/____/_____
Employee No. _____

1. Name_____
   Date of Birth _____ Sex: ☐ M ☐ F
2. Home Address_____
   STREET APT. NO.
   _____
   CITY STATE ZIP
   Home Telephone (___)_____
3. Occupation_____
   ☐ Clerical/Admin/Mgmt ☐ Light Manual
   ☐ Heavy Manual
4. Branch Location_____ Dept. Number _____
5. Supervisor's Name_____
   Supervisor's Tel. No. (___)_____
6. Last Actual Work Day_____, 19___
   Date of First Treatment_____, 19___
7. First Day You Were Unable To Work Because Of This Disability_____, 19___
8. Describe Disability_____
9. Is This Claim Based On An Accident? Yes ☐ No ☐
   Date_____
10. If You Have Returned To Work, Indicate Date Returned _____, 19___
11. Does Your Illness or Injury Arise Out Of Your Employment
    (Work Related)? Yes ☐ No ☐
    Have You Filed For Workers' Compensation?
    ☐ Yes ☐ No

If Yes, Date Filed _____ Amount Received $_____

12 You May Be Eligible For A State Plan Benefit Along With Your Voluntary Plan Benefit:
Have You received Wages From Any Other Employer or Company (including Self-Employment) In The Last 3 Months?
Yes ☐ No ☐
Name Of Other Employer

_____
Date Other Employment Began _____ Date Ended

_____
Are You Still Employed Or On Call? Yes ☐ No ☐

Employee's/Physician's Statement of Eligibility for
Short-Term Disability Benefits

Please verify the following information regarding your claim. Place an ☒ in the boxes below if correct. If not correct, please cross out the incorrect information and correct

☐ Social Security Number:	999-99-9999
☐ Employee Number:	XXXXXXXX
☐ Department Number	XXXXXX
☐ First Workday Unable to Work:	03-JAN-99
☐ STD Coverage:	XXXX
☐ Date of Coverage:	01-JAN-99
☐ Last Day Worked:	02-JAN-99

PART I. EMPLOYEE'S STATEMENT

I certify all of the information above (except as corrected) is accurate and that for the period covered by this claim, I was not working and was disabled. I hereby authorize my attending physician, practitioner, hospital, insurers, claims administrators, State of California, my employer(s), to furnish and disclose to VPA, Inc., my employer, or any of their authorized representatives, all facts concerning my medical condition and disability, wages or earnings, that are within their knowledge and to allow inspection of and provide copies of any medical records. I acknowledge my right to receive a copy of this authorization, which expires in one year. A photocopy of this authorization is as valid as the original.

Date:_____

Signature of Employee:_____

IMPORTANT!

If your physician has already called VPA or is going to call VPA, Inc. on the following toll free number (800)999-9999 you must sign this form above and return the signed form to VPA in the enclosed envelope. However, if your attending

physician's office is unwilling or unable to call the 800 number, please sign the form, have your physician complete the following statement and either fax the form to (800)888-8888 or mail the form to: **VPA, INC. PO BOX 9830, CALABASAS, CA. 91372-0830**

YOUR CLAIM CANNOT BE PROCESSED UNTIL VPA RECEIVES YOUR DOCTOR'S INFORMATION

PART 2: PHYSICIAN'S CERTIFICATE: (To Be Completed By Attending Physician)

IMPORTANT: Unless <u>each</u> question is answered, we cannot process benefit payment.

	ICD9 Code:	Diagnosis Description (Mandatory)
1. Primary Diagnosis		
2. Secondary Diagnosis:		

3. Occupation: ☐ Admin/Clerical/Management ☐ Light Labor ☐ Heavy Labor
   Is condition work related? Yes ☐ No ☐
4. If pregnancy-related Primary ICD9, Enter: LMP Date: _____
   EDC/DOC Date_____
5. Date of Disability:_____ Actual or Expected Return to Work Date (Mandatory)_____
6. Date Patient First Consulted You For This Condition:_
7. Patient Still Under Your Care For This Condition: ☐ Yes ☐ No
8. Was Patient Hospital confined As An Inpatient? ☐ Yes ☐ No
   Enter Dates of Hospitalization:

From _____Through _____

Name and Address of Hospital: _____

9. Was Patient Treated In a Hospital Surgical Unit Or Surgical Clinic?

☐ Yes ☐ No If Yes, Date: _____

I hereby certify that the above statement in my opinion truly describe the patient's disability (if any) and the estimated duration thereof, and that I am

_____ licensed to practice in _____

Type of Physician

_____ _____

Signature of Attending Physician Date of Signing This Form

Physician's Name as Shown on License:_____

Physician's Address:_____

Telephone Number:_____ State License Number: _____

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXX

10. RATE OF PAY FOR BENEFIT DETERMINATION

☐ Exempt Salaried Employee's Base Pay $_____ Per _____ as of last payroll period prior to disability

☐ Non-Exempt Hourly Employee's Rate of Pay $_____ Per Week. (Hourly rate of pay times average number of hours worked during last 2 completed pay periods prior to disability divided by 4)

11. REASON EMPLOYEE STOPPED WORKING

☐ Off-the-Job Illness or Injury
☐ On-the-Job Illness or Injury
(If so, has Work. Comp. Claim been filed?
☐ Yes ☐ No)

Temporary Layoff Without Pay (Eligible For Recall As Of _____
☐ Permanent Layoff without Pay (Not Eligible For Re-call) as Of _____

☐ Personal LOA Began on _____
☐ Termination As of _____
☐ Other _____

12. LAST DAY WORKED _____
FIRST DAY UNABLE TO WORK _____

13. SICK PAY/SALARY CONTINUATION/HOLIDAY PAY

☐ Employee not eligible for sick pay/salary continuation/vacation/holiday

☐ Employee has received or will receive ☐ sick pay ☐ salary continuation ☐ holiday pay for the period _____ through _____

☐ Plan benefits were integrated with sick pay benefits. Okay to pay plan benefits to the employee.

☐ Employee was accidentally paid full sick pay for the period _____ through _____. Pay plan benefits for this period to the Company.

14. RETURN TO WORK

If an employee has already returned to work or is available to return to work, please complete below:

☐ Employee has return to work on _____
☐ Employee was available to return to work on _____
☐ Temporary Employee reavailable for assignment as of _____

Date: _____
By: _____
Telephone No. ( ) _____

Return by FAX to VPA at (999)999-9999) or mail to VPA, Inc. XXXXXXXXXXX

CLAIM FOR CONTINUING DISABILITY BENEFITS

IMPORTANT	In order to receiver your new payment on schedule, you must complete and mail this form to VPA on or before 12-Oct-1992 in the enclosed envelope. Payment beyond 23-Oct-1992 will not be considered without an extension certified by your Physician.

If you have recovered or returned to work: A) Enter that date here: _____

B) Skip to 5 below – sign and mail IMMEDIATELY

If you expect to return to work within the next 2 weeks, enter that date here: _____

Indicate whether you have applied for or are receiving any other income:

If you are receiving any other income, indicate the date received

	Applied for	Receiving	Date Received
Social Security?	☐	☐	_____
State Disability from any State	☐	☐	_____
Workers Compensation	☐	☐	_____
Wages from any Employer or Self Employment			
Earnings?	☐	☐	_____

If disabled due to pregnancy and the baby has been born, indicate:
Baby's Date of Birth: _____
Type of delivery:
Normal ☐
Cesarean ☐

READ THIS CERTIFICATE BEFORE SIGNING

I hereby certify that during the period from 10/06/92 to 10/19/92, I was or will be disabled and unemployed and that the information given hereon is to the best of my knowledge, true and complete.

_____
Sign Your Name

_____
Daytime Phone Number

_____
Date Signed

☐ Please check this box if you have a change of address and write the new address on the back of the form
Claimant: JOE SMITH
Claim No.: 170494 SSN: 000-00-0000
Client: Restaurant Enterprises Group, Inc.

Detach and return in the enclosed envelope to:
VAP Inc., P.O. Box 9830, Calabasas, CA 91372-0830

Explanation of Benefits
for
JOE SMITH

Employer: Restaurant Enterprises Group, Inc.
Plan No.: 99-0729
Plan: CARROWS CA. FAMILY RESTAURANTS, INC.-CVP
Division:

Employee No:
Disability Date: 05/17/92
Location:
Soc-Sec-No:
Next Payment: 10/19/92
Cost Ctr:
Benefit Class: 1
Claim No. 170494
Approved Return to Work Date: 10/23/92
Statue: CONTINUING
Check No.: 027021
Control No.: 638657-035815-01

Summary of Benefits

Paid: 09/__/92
Paid Thru: 10/05/92
Paid Days: 14
Percent: 55
Weekly Gross Salary: $245.38
Weekly Benefit: $134.96
Gross Benefit: $269.92

Gross Benefit: $269.92
Offsets: $0.00
Adj-Gross Benefit: $269.92
Taxable Benefit: $0.00
Taxes Withheld: $0.00
Deductions: $0.00
Net Benefits: $269.92

Summary of Benefits Paid to date: $2,737.75

142 calendar days paid at 55%.

Direct any questions concerning this check or form to: VPA, Inc. (818)591-2772

The face of this check is in color

THE RESTAURANT
ENTERPRISES GROUP, INC.

BANK OF AMERICA
North America Division
P.O. Box 27128
Concord, California 99420

Not Valid for Amounts over $5,000.00
Not negotiable after 90 days

NO. 0141 027021

California Voluntary SDI Plan
PA, Inc. Claims Administrator

000-00-000
Claimant Social Security No.

CHECK DATE
10/08/92

PAY EXACTLY
$269.92

PAY THE SUM OF: TWO HUNDRED SIXTY-NINE AND 92/100 DOLLARS

TO THE ORDER: JOE SMITH
123 FIRST STREET
ANYTOWN, CA 99999

NOT NEGOTIABLE
"'-27021"' ':12100358': 12354 00844

Physician's Supplementary Criteria

IMPORTANT	If you have not recovered or returned to work, have your physician complete this form.

Must be completed by your present physician only if he finds that you will be unable to work on or beyond 10/05/92

Are you still treating the patient? ☐ Yes ☐ No
Last Office Visit:_____
Next Scheduled Visit: _____
Current diagnosis: _____
_____
ICD9 Code:

What complications (if any) continue to make the patient disabled? Be specific:
_____
When should patient be able to return to work? (A SPECIFIC DATE MUST BE GIVEN, EVEN IF IT IS AN ESTIMATE)

/ /

I hereby certify that the above statements, in my opinion, truly describe the patient's condition and the estimated duration thereof.

_____
Physician's Name (Please Print)

_____
Physician's Signature

_____
Signature Date

_____
Physician's Address

_____

Physician's License Number

_____

Physician's Telephone Number

_____

Joe Smith

Name of Patient

12-Mar-1957

Birth Date

Union Bank

Employer

Detach and return in the enclosed envelope to VPA Inc.

VPA Inc.
P.O. Box 9830
Calabasas, CA 9137-0830
(818) 591-2772

Explanation of Benefits
for
JOE SMITH

Employer: UNION BANK
Plan No: 99-0040
Plan: UNION BANK - CVP
Division: LOS ANGELES
Employee No: 03779
Disability Date: 09/21/92
Location: 17220
Soc-Sec-No: 000-00-0000
Cost Ctr:
Benefit Class: 1
Claim No. 177229
Approved Return to Work Date: 10/05/92
Statue: FIRST AND FINAL
Check No.: 058429
Control No.: 638522-035736-01

Summary of Benefits

Benefit not paid from 09/21/92 thru 09/22/92 due to sick pay from employer
Paid: 09/23/92
Paid Thru: 10/04/92
Paid Days: 12
Percent: 55
Weekly Gross Salary: $353.69
Weekly Benefit: $194.53
Gross Benefit: $333.48

Gross Benefit: $333.48
Offsets: $0.00
Adj-Gross Benefit: $333.48
Taxable Benefit: $0.00
Taxes Withheld: $0.00
Deductions: $0.00
Net Benefit: $333.48

Summary of Benefits Paid to date: $488.17

2 work days paid at 100%
12 calendar days paid at 55%

Your doctor states that you were released to return to work on 10/05/92.
You have 20 days to file for an extension.

Direct any questions concerning this check or form to: VPA, Inc. (818)591-2772

The face of this check is in color

UNION BANK
Los Angeles Registered Head Office
909 So. Main Street
Los Angeles, California 90018

/s/
UNION BANK

Not Valid for Amounts over $10,000.00
Not negotiable after 90 days

NO. 0169 058429

California Voluntary SDI Plan
VPA, Inc. Claims Administrator

000-00-000
Claimant Social Security No.

CHECK DATE
10/08/92

PAY EXACTLY
$333.48

PAY THE SUM OF: THREE HUNDRED THIRTY-THREE AND 48/100 DOLLARS

TO THE ORDER: JOE SMITH
123 FIRST STREET
ANYTOWN, CA 99999

NOT NEGOTIABLE

"058429 122000771 10037 6733

ADDENDUM F

HEWLETT-PACKARD COMPANY

INCOME PROTECTION PLAN

ADMINISTRATIVE SERVICES AGREEMENT FOR THE PERIOD JANUARY 1, 1995 THROUGH DECEMBER 31, 1995

ANNUAL PLAN ADMINISTRATION FEE

A. In consideration of the services provided by VPA (as delineated in Addendums B and C) the Organization agrees to pay VPA a quarterly Plan administration fee for the terms stated above, as follows:

PERIOD	FEE AMOUNT	DUE AND PAYABLE ON OR BEFORE
01/01/95 – 03/31/95	$225,000	01/01/95
04/01/95 – 06/30/95	$225,000	04/01/95
07/01/95 – 9/30/95	$225,000	07/01/95
10/01/95 – 12/31/95	$225,000	10/01/95

HEWLETT-PACKARD COMPANY

INCOME PROTECTION PLAN
ADMINISTRATIVE SERVICES AGREEMENT

AMENDMENT NO. 1

Effective January 1, 1997, Addendum D of the Administrative Services Agreement is amended and replaced in its entirety by the Addendum D attached.

IN WITNESS WHEREOF the parties hereto have executed this Agreement at the places and on the dates specified below.

VPA, INC.

Place: Calabasas, California By: /s/
Jack H. Bredehorn
Date: 11-12-96 Title: President

HEWLETT-PACKARD COMPANY

Place: Palo Alto, California By: /s/
D. Craig Nordlund
Date: 12/2/96 Title: Associate General Counsel & Secretary

HEWLETT-PACKARD COMPANY
EMPLOYEE BENEFITS ORGANIZATION

Place: Palo Alto, California By: /s/
Pete Peterson
Date: 12/2/96 Title: Senior Vice President

ADDENDUM D

HEWLETT-PACKARD COMPANY

INCOME PROTECTION PLAN

ADMINISTRATIVE SERVICES AGREEMENT
ANNUAL PLAN ADMINISTRATION FEE

FOR THE PERIOD JANUARY 1, 1997 THROUGH DECEMBER 31, 1997

A. In consideration of the services provided by VPA (as delineated in Addendums B and C) the Organization agrees to pay VPA a quarterly Plan administration fee for the terms stated above, as follows:

PERIOD	FEE AMOUNT	DUE AND PAYABLE ON OR BEFORE
01/01/97 – 03/31/97	$285,000	02/15/97
04/01/97 – 06/30/97	$285,000	05/15/97
07/01/97 – 09/30/97	$285,000	08/15/97
10/01/97 – 12/31/97	$285,000	11/15/97

B. The Organization agrees that the invoices forwarded by VPA for quarterly service fees are due and payable on or prior to the fifteenth (15) day of the second calendar month of each quarter.

HEWLETT-PACKARD COMPANY

INCOME PROTECTION PLAN
ADMINISTRATIVE SERVICES AGREEMENT

AMENDMENT NO. 2

Effective January 1, 1998, Addendum D of the Administrative Services Agreement is amended and replaced in its entirety by the Addendum D attached.

IN WITNESS WHEREOF the parties hereto have executed this Agreement at the places and on the dates specified below.

VPA, INC.

Place: Calabasas, California By: /s/
Jack H. Bredehorn
Date: 11-17-97 Title: President

HEWLETT-PACKARD COMPANY

Place: Palo Alto, California By: /s/
D. Craig Nordlund
Date: Dec. 10, 1997 Title: Associate General Counsel & Secretary

HEWLETT-PACKARD COMPANY
EMPLOYEE BENEFITS ORGANIZATION

Place: Palo Alto, California By: /s/
Susan Borwick
Date: 12/13/97 Title: Vice President, Human Resources

ADDENDUM D

HEWLETT-PACKARD COMPANY

INCOME PROTECTION PLAN

ADMINISTRATIVE SERVICES AGREEMENT ANNUAL PLAN ADMINISTRATION FEE

FOR THE PERIOD JANUARY 1, 1998 THROUGH DECEMBER 31, 1998

A. In consideration of the services provided by VPA (as delineated in Addendums B and C) the Organization agrees to pay VPA a quarterly Plan administration fee for the terms stated above, as follows:

PERIOD	FEE AMOUNT	DUE AND PAYABLE ON OR BEFORE
01/01/98 – 03/31/98	$305,000	02/15/98
04/01/98 – 06/30/98	$305,000	05/15/98
07/01/98 – 09/30/98	$305,000	08/15/98
10/01/98 – 12/31/98	$305,000	11/15/98

B. The Organization agrees that the invoices forwarded by VPA for quarterly service fees are due and payable on or prior to the fifteenth (15) day of the second calendar month of each quarter.

HEWLETT-PACKARD COMPANY

INCOME PROTECTION PLAN
ADMINISTRATIVE SERVICES AGREEMENT

AMENDMENT NO. 3
EFFECTIVE JANUARY 1, 1999

Addendum B, which describes VPA's Plan Administration Services, has been revised by the addition of VPA's Year 2000 Readiness Disclosure to page B6 attached. Addendum D, which describes the Annual Plan Administration Fee, is amended and replaced in its entirety by the Addendum D attached.

IN WITNESS WHEREOF the parties hereto have executed this Agreement at the places and on the dates specified below.

VPA, INC.

Place: Calabasas, California By: /s/
Jack H. Bredehorn
Date: 12-8-98 Title: President

HEWLETT-PACKARD COMPANY

Place: Palo Alto, California By: /s/
D. Craig Nordlund
Date: Dec. 16, 1998 Title: Associate General Counsel & Secretary

HEWLETT-PACKARD COMPANY
EMPLOYEE BENEFITS ORGANIZATION

Place: Palo Alto, California By: /s/
Susan Borwick
Date: Dec. 16, 1998 Title: Vice President, Human Resources

Produce and send an Employee Questionnaire to all closed claimants (with a paid return address envelope that is paid for by the Organization) requesting their opinion and thoughts on how the disability benefit processing system worked for them. Research any negative comments regarding VPA's services and determine what corrective action is needed, if any to eliminate similar complaints in the future. Compile a quarterly report on the results from the questionnaires and forward to the Company's Benefits Department with VPA's comments and the VPA action plan for improving customer satisfaction.

Year 2000 Readiness Disclosure

- VPA agrees that their main claim paying system (DCMS), electronic transmittal or reports and payroll feeds will be compliant by June 30, 1999.

ADDENDUM D

HEWLETT-PACKARD COMPANY

INCOME PROTECTION PLAN

ADMINISTRATIVE SERVICES AGREEMENT
ANNUAL PLAN ADMINISTRATION FEE

FOR THE PERIOD JANUARY 1, 1999 THROUGH DECEMBER 31, 1999

A. In consideration of the services provided by VPA (as delineated in Addendums B and C) the Organization agrees to pay VPA a quarterly Plan administration fee for the terms stated above, as follows:

PERIOD	FEE AMOUNT	DUE AND PAYABLE ON OR BEFORE
01/01 – 03/31/1999	$323,300	02/15/1999
04/01 – 06/30/1999	$323,300	05/15/1999
07/01 – 09/30/1999	$323,300	08/15/1999
10/01 – 12/31/1999	$323,300	11/15/1999

B. The Organization agrees that the invoices forwarded by VPA for quarterly service fees are due and payable on or prior to the fifteenth (15) day of the second calendar month of each quarter.

HEWLETT-PACKARD COMPANY

INCOME PROTECTION PLAN
ADMINISTRATIVE SERVICES AGREEMENT

AMENDMENT NO. 4
EFFECTIVE JANUARY 1, 2000

Addendum D, which describes the Annual Plan Administration Fee, is amended and replaced in its entirety by the Addendum D attached.

IN WITNESS WHEREOF the parties hereto have executed this Agreement at the places and on the dates specified below.

VPA, INC.

Place: Calabasas, California By: /s/
Jack H. Bredehorn
Date: 11-15-99 Title: President

HEWLETT-PACKARD COMPANY

Place: Palo Alto, California By: /s/
S.T. Jack Brigham, III
Date: 11-19-99 Title: Senior Vice President, Corporate Affairs and General Counsel

HEWLETT-PACKARD COMPANY
EMPLOYEE BENEFITS ORGANIZATION

Place: Palo Alto, California By: /s/
Susan Borwick
Date: 11-18-99 Title: Vice President, Human Resources

AGILENT TECHNOLOGIES, INC.

Place: Palo Alto, California

Date: 11-29-99

By: /s/
Jean M. Halloran

Title: Senior Vice President, Human Resources

ADDENDUM D

HEWLETT-PACKARD COMPANY

INCOME PROTECTION PLAN

ADMINISTRATIVE SERVICES AGREEMENT
ANNUAL PLAN ADMINISTRATION FEE

FOR THE PERIOD JANUARY 1, 2000 THROUGH DECEMBER 31, 2000

A. In consideration of the services provided by VPA (as delineated in Addendums A and B) the Organization agrees to pay VPA a quarterly Plan administration fee for the terms stated above, as follows:

PERIOD	FEE AMOUNT	DUE AND PAYABLE ON OR BEFORE
01/01 – 03/31/2000	$346,000.00	02/15/2000
04/01 – 06/30/2000	$346,000.00	05/15/2000
07/01 – 09/30/2000	$346,000.00	08/15/2000
10/01 – 12/31/2000	$346,000.00	11/15/2000

B. VPA will allocate the quarterly fee between Hewlett-Packard Company and Agilent Technologies, Inc. as instructed by Hewlett-Packard Company.

C. The Organization agrees that the invoices forwarded by VPA for quarterly service fees are due and payable on or prior to the fifteenth (15th) day of the second calendar month of each quarter.

Supreme Court, U.S.
FILED
MAY 2 5 2004
OFFICE OF THE CLERK

No. 03-1202

In The

Supreme Court of the United States

HEWLETT-PACKARD COMPANY
EMPLOYEE BENEFITS ORGANIZATION
INCOME PROTECTION PLAN,

Petitioner,

v.

DONALD JEBIAN,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF IN OPPOSITION

CHARLES J. FLEISHMAN
8383 Wilshire Blvd.
Suite 1030
Beverly Hills, CA 90211
323-653-9772
erisa@erisarights.com

Attorney for Respondent

BEST AVAILABLE COPY

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65 Fed. Reg. 70246, 70270 (Nov. 21, 2000) 7, 9, 10

OTHER AUTHORITIES

Robert L. Stern, et al., *Supreme Court Practice* §4.18, at 258 (8th ed. 2002) 11

INTRODUCTION

This is a case where ERISA long term disability benefits were denied, the claimant administratively appealed, and his appeal was ignored by the ERISA plan administrator for eleven months.

The denial of benefits was based on a finding by the plan administrator, Voluntary Plan Administrators, Inc. (VPA), that respondent, Donald Jebian, was not disabled. VPA's finding was contrary to the opinion of every doctor that examined the plaintiff or reviewed his medical records. VPA never had the medical records reviewed prior to denying the benefits, nor at any time after. The denial was based on a vocational report, previously rejected by VPA, written by a person whose expertise in the field is unknown, and based on unknown evidence and, VPA claimed, on a Functional Capacity Examination (FCE). In fact the FCE found that Mr. Jebian could not sit for longer than 20 minutes on an occasional basis, and could not do any forward reaching, pushing, pulling, or typing.

Contrary to the defendant's suggestion that Jebian was informed that VPA needed specific medical records and was waiting for Jebian to obtain them (Petition 7), VPA never asked Jebian to get the records, rather it wrote Jebian that it (VPA) would obtain the records. Further, the letter about the missing records was not sent by VPA to Jebian until March 15, 1999, 119 days after he administratively appealed (Pet. App. 7a n.4.) and VPA did not attempt to get the records until March 18, 1999, 122 days after the administrative appeal. ER 10. Finally, the "missing records" were in the possession of VPA by May 1999, four months before Jebian filed his complaint in the district court and five months before VPA's denial of the

administrative appeal. VPA did not seek a meaningful exchange of information with Jebian until after the expiration of time limits set by the plan and the then existing ERISA regulations. In fact, VPA, when specifically asked, refused to consider medical reports that Jebian thought important, and which the Court of Appeals found relevant.

A. STATEMENT OF THE CASE

1. The Plan. The Plan is self-funded. VPA is the claims administrator. ER 138. VPA is authorized by the Plan to decide administrative appeals of the termination of benefits. According to the Plan, VPA's discretion is limited to decisions made within specific time limits.

> "The Claims Administrator shall act upon each request for review within sixty (60) days after receipt thereof, . . . *In no event shall the decision of the Claims Administrator be rendered more than one hundred twenty (120) days after it receives the request for review*. . . . The Claims Administrator shall have the discretionary power to construe the language of the Plan and make the decision on review on behalf of the Organization. . . . *Within the time prescribed above, the Claims administrator shall give written notice of its decision to the claimant and the Organization*. . . . If a claimant has not received written notice that additional time is required for review is reached [sic] by the Claims Administrator, the claim shall be deemed to have been denied on review. If a claimant receives proper and timely notice that additional time is required for review, but does not receive written notice of the Claims Administrator's decision with respect to his or her claim within one hundred twenty (120) days after the Claims Administrator receives the

> request for review, the claim shall be deemed to have been denied on review." Emphasis added. ER 164-165.

To be eligible for benefits under the Plan, a claimant must meet the Plan's definition of total disability. He must be "continuously unable to perform any occupation for which he or she is or may become qualified by reason of his or her education, training or experience." ER 142.

2. Claim History. Donald Jebian was employed by Hewlett-Packard as a software engineer. ER 97. He began work for the company in October, 1983 and first stopped working because of disability resulting from back problems in May, 1995. On June 9, 1995 he had his first back surgery and a second back surgery on August 8, 1995.

On June 7, 1996, Jebian had surgery on his right shoulder to repair a torn rotator cuff. ER 126. On October 4, 1996, his left shoulder was operated on for a massive torn rotator cuff. ER 128. The left shoulder turned out to be irreparable. ER 33, 190, 191.

After trying to return to work twice, once in March 1996 and then again in May 1997 (ER 105), Jebian worked his last day for Hewlett-Packard on June 2, 1997. ER 113, 130. VPA handled each of the three off-work periods as separate claims.

On August 3, 1998, VPA wrote to Mr. Jebian that his disability benefits were being terminated. ER 120-122. On August 18, 1998 the Plaintiff administratively appealed the denial of benefits. ER 119. On the same date, he wrote to VPA asking that as part of the administrative appeal, the records in a prior claim be reviewed as well as the

report of a Dr. Stark which VPA already had in its possession as part of a prior claim. ER 93. Further argument and evidence was submitted by Jebian to VPA on November 11, 1998. Along with the November 11, 1998 letter, the plaintiff sent a report of a Dr. James W. Landes, orthopedist. ER 108-110.

Ten months passed with no ruling from VPA regarding the administrative appeal. On September 20, 1999 the complaint was filed in the district court.

To make a long story short, there has not been a single medical doctor that has ever examined Mr. Jebian with regard to his back and shoulder problems that has opined that he is anything other than totally disabled under the terms of the plan. ER 104, 200, 123, 54, 125, 131, 111-112, 88, 108-110. There has not been a single medical doctor that has ever reviewed his medical records that has opined anything other than that he is totally disabled. Neither the defendant nor VPA has ever had the plaintiff's medical records reviewed by a doctor. The sole basis for terminating the plaintiff's disability benefits appears to be a boiler plate "rehabilitation report." ER 120-122.

3. **The District Court Decision**. The district court granted summary judgement to the plan. It held that the standard of review was for abuse of discretion and that VPA did not abuse its discretion. In doing so, the district court made numerous critical clearly erroneous findings of fact many of which are discussed in the opinion of the Court of Appeals.

4. **The Court of Appeals' Decision**. The Court of Appeals reversed the decision of the district court, holding that the district court should have applied the de novo

standard of review. It reasoned that the plan language granted discretion to VPA so that normally its decisions would be reviewed by a court for abuse of discretion.

> "[B]ut the same instrument and the regulations that govern it set time boundaries within which that discretion must be exercised. We are just as bound by the Plan language deeming denial in the event that time limits are exceeded as we are bound by the Plan language that grants discretion to the Plan administrator. Decisions made outside the boundaries of conferred discretion are not exercises of discretion, the substance of the decisions notwithstanding. * * * [W]here the plan itself provides that a particular violation results in an automatic decision rather than one calling for the exercise of the administrator's discretion, that provision is as enforceable as the provision giving the administrator discretionary authority under other circumstances. Deference to an exercise of discretion requires discretion actually to have been exercised." Pet. App. 9a.

VPA did not make a decision on the administrative appeal during the time period in which, under the express words of the plan, it could exercise its discretion. Any decision that it made that it had no discretion to make under the plan was not entitled to discretionary review by the district court. The matter was remanded back to the district court for consideration under the de novo standard of review.

B. REASONS FOR DENYING THE PETITION

Hewlett-Packard is seeking certiorari based on an alleged split among the circuits regarding the interpretation

of a regulation that no longer exists. Before turning to the alleged split, Mr. Jebian wishes to address two fundamental problems with the petition, each of which, standing alone, warrant its denial. First, as explained in Part 1 below, the petition presents a question on a dead legal issue – an issue that has been superseded by a new Department of Labor regulation. Second, Part 2 discusses an impediment to review that is wholly ignored in the petition: the interlocutory nature of the Ninth Circuit's ruling below. Part 3 shows that even assuming these barriers to review did not exist, the split among the circuits posited by Hewlett-Packard is not genuine. Part 4 explains why the decision of the Ninth Circuit is correct.

1. The Department of Labor ERISA Regulation Has Been Revised and the Old Regulation Under Which the Purported Split Among the Circuits Developed and Under Which Mr. Jebian's Case Was Decided Has No Continuing Significance.

The relevant Department of Labor regulation that gave rise to the purported conflict among the circuits has been amended in ways that render irrelevant the legal issue on which Hewlett-Packard seeks review. Thus, even assuming that the conflict was, at one time, genuine and important, it provides no basis for granting review because it has no continuing importance.

In this case, a time limit of 60 days, with the possibility of an additional extension of 60 days, was imposed on deciding administrative appeals by a Department of Labor ERISA regulation. See 29 CFR §2560.503-1(h)(1)-(h)(2), (h)(4) (1998). Under the regulation, a failure to make a

timely decision resulted in the administrative appeal being "deemed denied." The issue presented by the present case and the other cases that have dealt with the regulation is: what is the correct standard of review to be applied by a court reviewing a "deemed denied" administrative appeal.

A new regulation, applicable to ERISA claims filed after January 1, 2002, has replaced the regulation involved in Mr. Jebian's case and all the other cases that Hewlett-Packard relies on for its argument that there is a split in the circuits. See 65 Fed. Reg. 70246, 70270 (Nov. 21, 2000) (codified at 29 CFR §2560.503-1(o) (2003)). The new regulation is different from the old regulation in several key respects, and those differences demonstrate that the question presented in the petition has no continuing importance.

First, the new regulation requires that administrative review of a claimant's appeal be conducted by an "independent" fiduciary, not by the person who made the initial denial decision or her subordinate. 29 CFR §2560.503-1(h)(3)(iii) (2003). This fundamental change is barely mentioned in the petition (at 3 n.1), but it underscores the Department of Labor's view that a full and fair review of the merits of an ERISA disability appeal is critically important and cannot be a rubber-stamp of the initial adverse determination. The new rule supports the conclusion that where an administrative appeal is concluded not on the merits, but by virtue of a failure to timely decide the appeal, district court review should be conducted de novo. A system that requires "independent" administrative review would be severely undermined if a "deemed denial," i.e., no administrative review, were to translate into deferential review by a court. The very independence

demanded in the new regulation would thus be negated. At the very least, it must be conceded that the new regulation requiring independent administrative reviews provides an entirely different legal backdrop for deciding the question presented, and the conclusions reached by the circuit courts under the old regulation provide little or no insight on how the issue will play out under the new one.

Second, and critically, as the petition notes in passing (at 3 n.2), the new regulation entirely eliminates the "deemed denial" concept. Instead, rather than continuing the fiction that the administrative appeal was acted upon, under the new regulation, the claimant is simply "deemed to have exhausted the administrative remedies under the plan," allowing the claimant to seek immediate judicial review. *id.* §2560.503-1(l) (2003). This change is highly relevant to the appropriate level of judicial review. With the notion of a "deemed denial" abolished, and thus without even a fictional decision before the trial court, it is difficult to see how a deferential, abuse-of-discretion standard can apply. After all, there would, by regulatory definition, be no decision or exercise of discretion to which the trial court could defer. This understanding forms part of the rationale for de novo review that the court below and other courts have applied in "deemed denial" cases. For present purposes, however, our point is not to defend this rationale in cases under the old regulation, but only to note that this rationale is far stronger as applied to cases under the new regulation, because the "deemed exhaustion" provision of the new regulation results in no "denial" at all. This justification for de novo review under the new regulation would likely attract uniform support from all circuits that may address the question in the future.

Finally, in promulgating its new regulation, the Department of Labor directly opined on the question presented. Hewlett-Packard, again in a footnote (at 21 n.8), acknowledges the Department's position that "the procedural minimums of the [new] regulation are essential to procedural fairness and that a decision made in absence of the mandated procedural protections *should not be entitled to any judicial deference.*" 65 Fed. Reg. at 70255 (emphasis added).

The question at the certiorari stage is whether the Department's view renders meaningless the alleged circuit split that developed under the old regulation. And it does. At the very least, the Department's view of the new regulation would surely require any circuit that had adopted abuse-of-discretion review for "deemed denials" to rethink its position. Recognizing that the Department's view would appear to deal its position (and its request for certiorari) a fatal blow, Hewlett-Packard makes the astounding claim that the Department's "statement [adopting de novo judicial review] is best understood as applicable to plans, such as the one in *Firestone*, that had not established procedures to comply with ERISA . . . and its implementing regulation." Pet. 21 n.8. Hewlett-Packard offers no reason why the Department's view should be "best understood" in this manner, nor could it, because the final rule says nothing of the sort. Nor would such a position make sense, since an ERISA plan that adopts the required procedures but fails to abide by them should hardly be entitled to more judicial deference than one that fails to adopt them at all.

Moreover, Hewlett-Packard's position is laid to rest when one looks at the Department's commentary accompanying the *proposed* rule. In a section entitled "Consequences

of Failure to Establish and Follow Reasonable Claims Procedures," 63 Fed.Reg. 48390, 48397 (Sept. 9, 1998), the agency stated that, under the new regulation, a claimant who is not provided the procedural protections will be deemed to have "exhausted the administrative remedies available to him" "if the plan fails to provide or *abide by* procedures that meet the regulatory minimum standards." *Id.* (emphasis added). In this situation – explicitly including cases where the plan has established the minimal procedures but failed to "abide by" them – the claimant may go directly to court and "any decision that may have been made by the plan with respect to the claim is not entitled to the deference that would be accorded to a decision based upon a full and fair review that comports with the requirements of section 503 of the Act." *Id.*

Thereafter, in the agency's commentary accompanying the final rule, the Department addressed "[m]any commenters representing employers and plans" who argued against the deemed exhaustion provision and urged instead adoption of a "good faith compliance" or "actual harm" standard. 65 Fed.Reg. at 70255-56. The agency rejected those suggestions because it "believe[d] that plans should be held to the articulated standards as presenting a minimum procedural regularity that warrants imposing an exhaustion requirement on claimants." *Id.* at 70256. Thus, "[a]t a minimum, claimants denied access to the statutory administrative review process should be entitled to take a claim to a court under section 502(a) of the Act *for a full and fair hearing on the merits of the claim.*" *Id.* (emphasis added).

This regulatory history shows that the Department rejects the Hewlett-Packard's position on the merits. It also demonstrates that the Department's view on the

standard of judicial review is tied, at least in part, to the agency's new "deemed exhaustion" rule. It is thus very likely that all circuits, when faced with cases involving the *new* regulation, will adopt the agency's view that de novo judicial review is appropriate in cases like Mr. Jebian's.

In sum, the petition asks the Court to review a question posed by a dead regulation, which has been replaced by a new regulation that dramatically alters the legal landscape. Review should be denied on that ground alone.

2. Review Should Be Denied Because The Ninth Circuit's Decision Is Interlocutory.

Even if we were to assume away the obsolescence of the question presented, another fundamental barrier to review remains. Although this Court has jurisdiction under 28 USC §1254(1) to review interlocutory decisions of federal courts of appeals, it rarely does so. "Ordinarily, in the certiorari context, 'this court should not issue a writ of certiorari to review a decree of the circuit court of appeals on appeal from an interlocutory order, *unless it is necessary to prevent extraordinary inconvenience and embarrassment in the conduct of the cause.*'" Robert L. Stern, et al., *Supreme Court Practice* §4.18, at 258 (8th ed. 2002) (quoting *American Construction Co. v. Jacksonville, T.&K.W. Railway Co.*, 148 U.S. 372, 384 (1893) (emphasis added)); see also, e.g., *Hamilton-Brown Shoe Co. v. Wolf Bros. Co.*, 240 U.S. 251, 258 (1916) (interlocutory decisions are reviewed only in "extraordinary cases"). The posture of this case is anything but "extraordinary." Mr. Jebian filed a garden-variety ERISA claim seeking the review of a long-term disability benefits determination in the federal

district court. The district court granted summary judgment to the defendant plan. The Ninth Circuit reversed and held simply that, because the district court erred in failing to review the plan's benefits denial on a de novo basis, Mr. Jebian's claim survives summary judgment and must be resolved on its merits by the trier of fact. The plan retains all defenses it may have and the trier of fact is free to find in favor of the plan on any permissible ground. If Hewlett-Packard prevails on the ultimate disability question or on any other dispositive ground, review on the question presented in the petition would not be necessary or appropriate.

Of course, Mr. Jebian believes that he will prevail on the merits. If that occurs, there will be a final judgment from which the plan may appeal and ultimately present the standard of review question, and any other federal issue, to this Court for resolution. This case is a less appropriate vehicle for immediate, interlocutory review than was true in *Virginia Military Institute v. United States*, 508 U.S. 946 (1993) ("*VMI*"), where the Court denied review because of the case's interlocutory posture. In *VMI*, the Fourth Circuit had issued a final decision holding that the Commonwealth of Virginia's sponsorship of a military college for men only was unconstitutional, but the district court had yet to rule on the appropriate remedy. The Court denied certiorari on the ground that the decision was not sufficiently final because the remedy phase had not been completed. See *id.* (Scalia, J., concurring). The Court recognized that there would be time enough to review the decision if that were necessary after the remedial portion of the case was decided. In fact, it later did so. *United States v. Virginia*, 518 U.S. 515 (1996). Here, of course, there is no decision regarding liability, let

alone the appropriate remedy, and thus interlocutory review is particularly inappropriate.

3. There Is No Real Split Among The Circuits.

The issue raised by the Ninth Circuit's decision in this case is whether or not there is a change in the standard of review from arbitrary and capricious (sometimes referred to as abuse of discretion or deferential review) to de novo when a plan administrator, granted discretionary powers with regard to the granting of claims, fails to timely decide administrative appeals. At first glance, a review of the decisions dealing with the question indicates a conflict in the answers given by some of the circuit courts. A closer review, however, shows otherwise. The various courts are working their way to a consensus.

There is no conflict between the Ninth Circuit's ruling below and the opinions of the Tenth Circuit in *Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625 (10th Cir. 2003) and the Third Circuit in *Gritzer v. CBS, Inc.*, 275 F.3d 291 (3d Cir. 2002). Indeed, decision below was in part based on the reasoning in both *Gilbertson* and *Gritzer*. All three hold that the failure to timely decide an administrative appeal calls for a de novo review of a denial of benefits. All three cases recognize the impossibility of reviewing for abuse of discretion a denial of benefits that is not the result of an exercise of discretion but rather the passage of time. *Gilbertson*, which followed *Gritzer*, recognized an exception to the rule when there is an ongoing productive investigation of the claim in which both parties participate. The decision below recognizes the exception.

McGarrah v. Hartford, 234 F.3d 1026 (8th Cir. 2000) held that while a failure to render a timely decision in an administrative appeal was a serious procedural irregularity, it would not necessarily "strip a plan administrator of the deferential standard of review." It was pointed out, under the facts of that case, that the initial decision to deny benefits followed a review of all of the evidence submitted to the administrator and that no new evidence was submitted by the claimant when he administratively appealed. Therefore, there was an actual decision, that considered all of the claimant's evidence, made by the administrator that was the result of its exercise of discretion that the Court could review for abuse of that discretion. If there had been substantial new evidence submitted by the claimant at the time of the administrative appeal, the standard of review would probably have been de novo since the only decision of the administrator, a decision made prior to the administrative appeal, would not have taken that additional evidence into consideration.

This analysis is supported by the Eighth Circuit's later decision in *Seman v. FMC Corporation*, 334 F.3d 728 (8th Cir. 2003). The Court held that de novo review applied to a denial of benefits when the plan in question granted full discretion to the administrator but the administrator had failed to timely decide the administrative appeal. The Court distinguished its earlier decision in *McGarrah* by pointing out that Seman, unlike McGarrah, submitted substantial amounts of medical evidence in connection with his administrative appeal, evidence that was not before the plan administrator when it initially denied his appeal. Thus, a deferential review of the administrator's denial of benefits could not be done since that exercise of the administrator's discretion failed to consider

the substantial newly submitted evidence. So the Eighth Circuit, in the end, is in conformity with the Third, Ninth, and Tenth. In order for there to be a review for abuse of discretion, there has to be a decision that is the result of the exercise of discretion granted by the plan. Otherwise, the standard of review is de novo.

The Sixth Circuit in *Daniel v. Eaton Corp.*, 839 F.2d 263 (6th Cir. 1988) held, without much discussion or analysis, that the standard of review remains abuse of discretion "whether the appeal is actually denied or deemed denied." Twelve years later that circuit had an opportunity to examine its holding in *Daniel*. Although it did not need to reverse the holding, in dicta it stated that there is "undeniable logic in the view that a plan administrator should forfeit deferential review by failing to exercise its discretion in a timely manner." *University Hospitals of Cleveland v. Emerson Electric Co.*, 202 F.3d 839, 846 n.3 (6th Cir. 2000). Thus, the Sixth Circuit seems to be moving in the direction of a consensus with the others that have faced the issue, and it would have a clear basis for doing so under the new regulation. See *supra* Part 1.

Southern Farm Bureau v. Moore, 993 F.2d 98 (5th Cir. 1993), is a case that is at odds with the present state of ERISA litigation. One can safely say that it was wrongly decided. The claimant was never given an opportunity to ask for an administrative appeal or to submit additional evidence challenging the original denial of benefits. The claimant was denied a full and fair review by way of administrative appeal. Furthermore, the Court refused to consider the new evidence that the claimant had and that, in a normal situation, she could have presented to the plan administrator and ultimately to the trial court. The plan

in that case, unlike all of the other cases that are discussed, did not grant discretionary authority to the plan administrator. The Fifth Circuit held that review of factual findings, as opposed to plan interpretations, of a plan administrator, regardless of whether or not discretion is granted to the administrator, are always to be reviewed for abuse of discretion. *Southern Farm* is in conflict, on numerous issues, with most ERISA decisions that temporally follow it. For example, most Circuits hold that de novo review, when it applies, covers both interpretations of a plan and the factual findings of the plan administrator.

4. The Court of Appeals' Decision Is Correct.

"ERISA further requires that plan procedures 'afford a reasonable opportunity for a full and fair review' of dispositions adverse to the claimant." *Black & Decker v. Nord*, 538 U.S. 822, 830 (2003). Given this entitlement to a full and fair review, the duty of the plan administrator is more than just to reach a decision that is not arbitrary and capricious. It is to reach a correct decision, a decision based "on the merits of the claim." 29 CFR §2560.503-1(l) (2003). One of the safeguards to reaching a correct decision is administrative review.

Application of the arbitrary and capricious standard of review by a court to a decision that was not actually made after a full and fair consideration of the evidence, but which simply resulted from a claim being deemed denied by a failure to timely decide it, would encourage claim administrators to make no decisions at all. This would delay much needed benefits and require the courts to sift through the evidence, once the frustrated claimant has

filed suit, to come up with judicial rationales for denials that would pass the arbitrary and capricious test. The courts would in effect become the decision makers and, rather than looking for the correct decision in a given case (as administrators are supposed to do), judges would be looking for all possible ways to justify denials of benefits. The trial judge would become a biased plan administrator. Claims would be examined with an eye to finding reasons for their denial rather than to reach decisions on the merits.

Time limits established by ERISA regulations recognize that a person who needs ERISA benefits, needs them sooner rather than later. A disabled person is without work and lucky to be living on savings. Oftentimes a person in need of medical treatment needs it now; tomorrow may be too late. While there may be times when a plan administrator is justified in taking longer than the time set forth in the regulation to make a decision, it must be recognized that such delays are always at a cost to the needy claimant.

In this case, there was no justification for a delayed decision at all. VPA did not seek what it calls the missing medical evidence until 122 days after the administrative appeal. VPA, although it received the "missing medical evidence" in May 1999, had still not made a decision regarding the administrative appeal at the time Jebian finally filed the complaint, on September 20, 1999, four months later. At no time did VPA ever ask for the additional time that the regulations allowed it to ask for. It just took its time at doing nothing and would have continued to do nothing had not the plaintiff filed the complaint in district court. The ruling of the Ninth Circuit gives plan

administrators a powerful incentive to reach decisions in a timely fashion.

The argument, made by the defendant, that plan administrators will make erroneous denials if forced to meet the time limits mandated by the regulation, is fallacious for several reasons. First of all, nobody knows how many denials, timely but without a full and fair review, are presently made by administrators simply so that they can meet the ERISA time limits. Let's face it, no plan administrator admits to making a decision without a full and fair review. If the number is small, it means that the problem posed by the defendant is also small. If the number is large then defendant's argument goes too far. It means that either the ERISA time regulations should be eliminated altogether or the arbitrary and capricious standard of review should be eliminated. The two are incompatible. Yet, we know that the Department of Labor has decided that the time limits are important to the administration of ERISA claims. In fact, the Department's new regulation shortens the time in which a decision must be made from 60 days to 45. 29 CFR §2560.503-1(f)(3) (2003), thus rejecting implicitly Hewlett-Packard's claim that plans need more time to conduct full and fair administrative reviews.

The defendant's argument is wrong for a second reason. Erroneous timely denial decisions, according to the argument, would be made so that administrators could preserve the arbitrary and capricious standard of review. The argument assumes that the administrators are concerned about being forced to wrongly deny claims. It assumes the good faith of the administrators and their strong desire to do the right thing vis-a-vis claimants. The answer to the argument's dilemma between a timely

decision and a just decision is simple. If a plan administrator makes what it knows to be a timely decision that may be wrong, it has months until the plaintiff files the complaint and the matter works its way through the court to a trial date, in which to fully examine the claim in every detail. If it finds that its denial was wrong, it can change its decision and pay the benefits due.

In cases where the plan administrator has not denied the administrative appeal before the filing of a lawsuit, it is almost impossible to apply the arbitrary and capricious standard of review. This case is a good example of that impossibility. A report by a Dr. Stark (ER 104, 200), that the plaintiff requested the administrator to consider (ER 93) and found relevant by the Court of Appeals, was never considered by the defendant even in its final post complaint denial letter. A report by a Dr. Landes (ER 108-110) was not considered by the defendant until the post complaint denial letter. SER 60-64. The plaintiff's arguments that the Rehab West report was faulty were never considered at all. ER 106. Which decision of the defendant was the court supposed to review for abuse of discretion? The pre-complaint decision that the plaintiff administratively appealed from or the post complaint decision? If we say that the court should apply abuse of discretion review to the pre-complaint decision, is justice served by a court ignoring the plaintiff's evidence and argument that was raised in the administrative appeal? Surely nothing could more clearly be a denial of a full and fair review of the claim. Not only did the defendant ignore the plaintiff's evidence and argument but now a court will also.

Abuse of discretion review cannot apply to a post complaint decision either. By the time of that decision the parties, being that they are on the opposite sides of a

federal lawsuit, are polarized in adversarial positions. ERISA and its abuse of discretion standard of review assumes that a fiduciary is searching for the truth rather than a litigant presenting a justification for its actions. Applying the arbitrary and capricious standard of review to a post complaint denial of an administrative review fails to recognize that the post complaint denial is probably the result of a conflict of interest.

Finally, de novo review is the default standard of review. Only when plan documents confer a fiduciary with discretion to determine facts and interpret terms of the plan does the abuse of discretion standard of review apply to a court's review of a denial of ERISA benefits. In this case discretion is granted to VPA only with regard to decisions that it makes within specific time limits. The Ninth Circuit's decision recognized that VPA's decision was outside of the time limit in which it was required to exercise discretion under the terms of the plan, regardless of the existence of the regulation. Thus, even if we ignore the old regulation, VPA's decision was not entitled to deferential review. The grant of discretion in the plan did not extend to decisions made after a specific time.

In *Rush Prudential v. Moran*, 153 L.Ed.2d 375, 385 (2002) this Court wrote with regard to deferential review and ERISA cases, "Not only is there no ERISA provision directly providing a lenient standard of judicial review of benefit denials, but there is no requirement necessarily entailing such an effect even indirectly. When this Court dealt with the review standards on which the statute is silent, we held that a general default rule of *de novo* review could be replaced by deferential review if the ERISA plan itself provided that the plan's benefit determinations were matters of high or unfettered discretion,

(citation omitted). Nothing in ERISA, however, requires that these decisions be so 'discretionary' in the first place; whether they are is simply a matter of plan design or drafting of an HMO contract."

Most ERISA plans do not have specific time limits written into them. In this case time limits are in the plan documents; they limit the discretion granted to VPA; they are contractual. No grant of discretion is given to the plan administrator in this case for decisions made outside of the time limits set forth in the plan. Decisions made without discretionary authority are not entitled to abuse of discretion review by the courts whether they are timely or not. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). The Ninth Circuit's decision simply recognizes the fact that VPA's decision to deny Mr. Jebian's administrative appeal was not entitled to differential treatment by the courts simply because the plan documents do not grant discretion to VPA to make the decision.

CONCLUSION

The petition for writ of certiorari should be denied.

Respectfully submitted,

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IN THE

Supreme Court of the United States

HEWLETT-PACKARD COMPANY EMPLOYEE BENEFITS ORGANIZATION INCOME PROTECTION PLAN,

Petitioner,

v.

DONALD JEBIAN,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

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REPLY BRIEF FOR PETITIONER

None of the four reasons advanced by respondent is sufficient to warrant denial of the petition, which presents an important and recurring question of federal law that has generated a three-way split of authority among the courts of appeals.

I. The Amendment To The ERISA Regulation Does Not Affect The Continuing Importance Of The Question Presented

Jebian first contends that review is unnecessary because the Department of Labor has amended its claims-processing regulation. Opp. 6-7 (citing 29 C.F.R. § 2560.503-1 (1998 & 2003)). He asserts that the new regulation differs from the old one in three "key respects" that purportedly "demonstrate that the question presented in the petition has no continuing importance." Opp. 7. Jebian is wrong.

1. Under the former regulation (and the Plan at issue here), an administrative appeal could be decided by the *same* person or entity that made the initial benefits determination. Under the amended regulation, the internal appeal must be decided by a person or entity *other than* the one that made the initial determination. As explained in the petition, "[t]he new regulation affects the *identity* of the person or entity with the discretionary authority to resolve internal appeals, but does not speak to the standard of review applicable if such appeals are deemed denied as a result of the passage of time limits set by regulation or plan documents." Pet. 22 n.9.

Jebian contends that "[t]he new rule supports the conclusion that where an administrative appeal is concluded not on the merits, but by virtue of a failure to timely decide the appeal, district court review should be conducted de novo." Opp. 7. But this assumes the answer to the very question that has divided the Circuits—*i.e.*, whether the administrator's

decision to allow an appeal to be denied by the passage of time is or is not a decision "on the merits" (or, relatedly, an exercise of discretion). Jebian makes no effort to respond to the Plan's showing that even a failure to act is, under the common law of trusts, reviewed for abuse of discretion. Pet. 18. The new regulation has no bearing on this issue.

Jebian also contends that "the conclusions reached by the circuit courts under the old regulation provide little or no insight on how the issue will play out under the new one." Opp. 8. But he offers nothing to support this bald speculation. Nor does he attempt to refute the extensive treatment of the new regulation in the petition (at 3 nn.1-2, 21-22 n.8, and 22 n.9), or to rebut the Plan's conclusion that "[t]he amendments to the ERISA regulation do not resolve the issue of what standard of review applies in the context of a deemed denial." Pet. 22. Most importantly, the new regulation does not purport to, and does not in fact, resolve the existing conflict among the courts of appeals on this issue.

2. Under the former regulation (and the Plan at issue here), appeals were "deemed denied" upon the expiration of the established time period. Under the amended regulation, a claimant is "deemed to have exhausted" administrative remedies. Jebian contends, wrongly, that the new regulation "eliminates" the "notion" of a deemed denial, such that "there would, by regulatory definition, be no decision or exercise of discretion to which the trial court could defer." Opp. 8. As explained in the petition (at 20-21), the revised language merely codifies this Court's recognition that deemed denials enable a claimant to initiate judicial proceedings without further participation in the administrative process. *Mass. Mut. Life Ins. Co.* v. *Russell*, 473 U.S. 134, 144 (1985). Independently of any regulation, the Plan (like most plans) provides that appeals are deemed denied following passage of a certain period of time. Pet. App. 142a. As this Court has explained, the level of discretion afforded adminis-

trative decisions "is simply a matter of plan design"; the standard of review is *not* controlled by statute or regulation. *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355, 385-86 (2002). Thus, the question presented remains live as a matter of plan design notwithstanding the amendment of the claims-processing regulation.

3. Jebian points to the "regulatory history" of the amended regulation and contends that the Department of Labor has indicated that "de novo judicial review is appropriate" in cases such as this one. Opp. 9-11. As explained in the petition (at 21-22 n.8), the Plan reads this same history—and the Department's interpretive guidance, which Jebian ignores—quite differently. The Labor Department has expressly recognized that where a plan establishes procedures that meet regulatory standards, the plan should receive deference so long as it substantially complies with those standards. *See* Pet. 21-22 n.8. But the parties need not further debate the point. If the Court has any questions in this regard, it would be appropriate to invite the Solicitor General to file a brief explaining the views of the Labor Department.

II. This Court Frequently Reviews Summary Judgment Rulings Concerning The Standard Of Review

Jebian's second principal argument is that certiorari should be denied because the decision below is interlocutory. Opp. 11. The purpose of restraint while a case is interlocutory is to avoid "unnecessary and inappropriate constitutional adjudications," Robert L. Stern et al., *Supreme Court Practice* § 18.1 at 802 (8th ed. 2002), or to avoid inconvenience, litigation costs, and "delay in determining ultimate justice." *Gillespie* v. *U.S. Steel Corp.*, 379 U.S. 148, 152-53 (1964). Where, however, a case "involve[s] an issue 'fundamental to the further conduct of the case,'" review may well be appropriate. *Land* v. *Dollar*, 330 U.S. 731, 734 n.2 (1947) (reviewing interlocutory ruling) (citation omitted). Procedural rulings that significantly influence the course of further liti-

gation frequently give rise to interlocutory review. *See, e.g.*, *Beacon Theatres* v. *Westover*, 359 U.S. 500, 501 (1959) (granting mandamus to address right to jury trial); *Larson* v. *Domestic & Foreign Commerce Corp.*, 337 U.S. 682, 682 (1949) (reviewing jurisdictional issues following appellate reversal of grant of motion to dismiss). This Court reviews decisions reversing summary judgment—the precise posture presented here—on a regular basis. *See, e.g.*, *City of Cuyahoga Falls* v. *Buckeye Cmty. Hope Found.*, 538 U.S. 188, 193-94 (2003); *City of Los Angeles* v. *David*, 538 U.S. 715, 716 (2003); *Texas* v. *Lesage*, 528 U.S. 18, 19-20 (1999).

Cases involving the applicable standard of review present the quintessential candidate for interlocutory review. *See, e.g.*, *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 108 (1989) (reviewing appellate reversal of grant of summary judgment to address circuit split concerning standard of review in ERISA benefits cases). In such cases, the issue often is crystallized only at an intermediate stage and may later be rendered moot or unreviewable. In this case, for example, the standard of review was outcome-determinative at the appellate level. And while (if the decision below stands) there will be further proceedings in the district court, the Plan may be effectively precluded from seeking review of the Ninth Circuit's decision if it prevails on remand. Thus, the procedural posture of the case is no obstacle to this Court's exercise of its discretionary certiorari jurisdiction. *See* Stern et al., *supra*, § 4.18 at 260 ("the interlocutory status of the case may be no impediment to certiorari where the opinion of the court below has decided an important issue, otherwise worthy of review, and Supreme Court intervention may serve to hasten or finally resolve the litigation").

III. The Question Presented Has Deeply Divided The Courts Of Appeals

Jebian's third argument is that there is no "real" conflict among the Circuits. Opp. 13. Although numerous federal

judges, including the authors of both opinions below, have expressly recognized the conflict at issue, Jebian attempts to explain it away. Jebian is wrong; the conflict is genuine.

1. Jebian concedes that "[a]t first glance, a review of the decisions dealing with the question [presented] indicates a conflict" but asserts that "[a] closer review" indicates that "[t]he various courts are working their way to a consensus." Opp. 13. Of course, that they have not reached "consensus" is another way of acknowledging that there is an existing conflict, as the Plan has previously demonstrated. Pet. 11-17.

The Judiciary is not as sanguine as Jebian regarding the absence of a conflict in this area. In the decision under review, both the majority and the dissent expressly noted the conflict among the Circuits. Pet. App. 12a-14a ("conclusions in similar cases vary"), 21a ("the majority's conclusion conflicts with all but one of the decisions that have dealt with the precise issue we face"). The Tenth and Eleventh Circuits, likewise, have observed the same conflict. *Gilbertson* v. *Allied Signal, Inc.*, 328 F.3d 625, 633 (10th Cir. 2003); *Torres* v. *Pittston Co.*, 346 F.3d 1324, 1332-33 (11th Cir. 2003).

And a number of district courts, themselves struggling with the appropriate standard of review, have noted the conflict of authority among the appellate courts. *See, e.g.*, *Campanella* v. *Mason Tenders' Dist. Council Pension Plan*, 299 F. Supp. 2d 274, 289-90 (S.D.N.Y. 2004) (reviewing the various approaches that have developed and choosing deferential review); *DiCamillo* v. *Liberty Life Assurance Co.*, 287 F. Supp. 2d 616, 626 (D. Md. 2003) (same: "applying a *de novo* standard of review where deference is generally warranted solely because of a procedural error is an extreme measure that is inconsistent with the settled law of ERISA"); *Wertheim* v. *Hartford Life Ins. Co.*, 268 F. Supp. 2d 643, 664 (E.D. Va. 2003) (same: "The majority's holding in [the original panel opinion in] *Jebian* is unpersuasive. Instead, it is Judge Tashima's dissent in *Jebian* that has it right . . . .").

The Plan submits that these jurists are more familiar with identifying "real" conflicts than Jebian is.

2. Jebian's attempt to explain away the conflict fares no better than his effort to deny its existence. Jebian begins by depicting the ruling below as similar to both the Tenth Circuit's *Gilbertson* ruling and the Third Circuit's decision in *Gritzer* v. *CBS, Inc.*, 275 F.3d 291 (3d Cir. 2002). Opp. 13. Although all three courts ultimately applied a *de novo* standard of review, the paths they followed differed significantly. In *Gritzer*, the Third Circuit adopted a clear and automatic rule that the occurrence of a deemed denial results in a forfeiture of discretion and *de novo* review. 275 F.3d at 296. In *Gilbertson*, by contrast, the Tenth Circuit concluded that "a 'substantial compliance' approach is appropriate .... Accordingly, our holding does not require that every decision that comes on the 61st or 121st day following the claimant's notice of appeal must be subject to plenary review in federal court." 328 F.3d at 634-35.

In the ruling below, the Ninth Circuit initially stated that "[d]eemed denials are not exercises of discretion. They are therefore undeserving of deference under *Firestone*, and a *de novo* standard of review applies." Pet. App. 11a-12a. That formulation of the rule tracks *Gritzer*. Later, however, the court paid lip service to the Tenth Circuit's "substantial compliance" approach, suggesting that deferential review might be appropriate for "inconsequential violations of the deadlines." *Id.* 14a-15a. As shown in the petition (at 16 n.7), the Ninth Circuit ignored the district court's finding of substantial compliance in order to evade the exception it purported to recognize, and in a subsequent case that court has demonstrated that essentially all procedural missteps will result in *de novo* review. In reality, the Ninth Circuit adheres to the inflexible *de novo* rule employed by the Third Circuit, and that rule differs markedly from the Tenth Circuit's substantial compliance approach. *See* Pet. 13-17.

Jebian then argues that the Eighth Circuit's case law "is in conformity with" the decisions of "the Third, Ninth, and Tenth" Circuits. Opp. 14-15. Jebian misunderstands the Eighth Circuit's decisions in *McGarrah* v. *Hartford Life Insurance Co.*, 234 F.3d 1026 (8th Cir. 2000), and *Seman* v. *FMC Corp. Retirement Plan for Hourly Employees*, 334 F.3d 728 (8th Cir. 2003). In *McGarrah*, the Eighth Circuit held that "the mere presence of a procedural irregularity is not enough to strip a plan administrator of the deferential standard of review" and that, in order to trigger *de novo* review, a claimant must demonstrate that the irregularity "raises 'serious doubts as to whether the result reached was the product of an arbitrary decision or the plan administrator's whim.'" 234 F.3d at 1031 (citation omitted). The court concluded that the record failed to demonstrate such doubts and, therefore, reviewed the administrator's decision for an abuse of discretion. *Ibid.*; *see also* Pet. 14-15. In *Seman*, the Eighth Circuit followed *McGarrah* and merely concluded that the record in that case raised sufficiently serious doubts as to the result to warrant *de novo* review. 334 F.3d at 733.

The principal difference between *McGarrah* and *Seman* is that in *Seman*, the claimant submitted the vast majority of his medical evidence after the initial denial of his claim, and the court was left without a final ruling by the administrator addressing the effect of that evidence on the claimant's appeal. In *McGarrah*, by contrast—as with Jebian's claim—the bulk of the medical evidence was submitted before the deemed denial. Thus, the Eighth Circuit operates from a presumption of deferential review and continues to focus on whether the process as a whole raises doubts regarding the soundness of the ultimate decision, a rule that contrasts starkly with the approach followed by the Third and Ninth Circuits.

Jebian also endeavors to sweep under the rug the clear holdings of the Fifth and Sixth Circuits applying an abuse of

discretion standard of review to deemed denials. Opp. 15-16. With regard to *Daniel* v. *Eaton Corp.*, 839 F.2d 263 (6th Cir. 1988), the best that Jebian can do is to observe that a different panel of the Sixth Circuit has noted, in a footnote that is plainly dictum, that there is "undeniable logic" in the *de novo* approach rejected in *Daniel*. Opp. 15. As the petition demonstrates (at 12 n.5), *Daniel* undeniably remains the law of the Sixth Circuit, and Jebian does not seriously dispute that point. He then blithely asserts that *Southern Farm Bureau Life Insurance Co.* v. *Moore*, 993 F.2d 98 (5th Cir. 1993), was "wrongly decided" because it purportedly is out of step with ERISA case law with respect to issues that are simply not presented in this case. Opp. 15. Jebian's contention that *Moore* was decided incorrectly does nothing to minimize the fact that the Fifth Circuit has adopted a rule that is directly contrary to the decision below, and he offers no basis for his implied conclusion that the Fifth Circuit would decide the issue differently today.

The inescapable reality is that the Circuits are deeply divided with respect to the standard of review applicable to deemed denials, and the various approaches show no signs of converging. Review by this Court is warranted.

IV. The Putative Correctness Of The Decision Below Is No Barrier To Review

Jebian's fourth, and final, ground for resisting certiorari is that the Ninth Circuit reached the correct result. Opp. 16. Right or wrong, however, the decision below exacerbates an existing circuit split that merits review.

Indeed, despite the grounding of ERISA in trust law, repeatedly recognized by this Court and many other courts, *see, e.g.*, *Firestone*, 489 U.S. at 111, Jebian side-steps entirely the detailed examination of the applicable trust law principles presented in the petition (at 17-21). Rather than responding to those arguments directly, Jebian offers a series of largely

speculative policy-based rationales to justify the result below. Opp. 16-21. Jebian's arguments lack merit

Jebian first argues that applying an abuse of discretion standard "would encourage claim administrators to make no decisions at all." Opp. 16. There is no evidence whatsoever to support such conjecture. Quite simply, no party stands to gain from a policy of not deciding benefits claims. Indeed, while a timely and well-reasoned explanation of the reasons for denying a claim may convince many a claimant not to pursue matters further, not issuing a decision virtually assures that a claimant will seek judicial review. And the complete failure to make any decision could well constitute an abuse of discretion. Pet. 18-19.

Jebian then turns his attention to the financial condition of disabled workers, who need their ERISA benefits "sooner rather than later." Opp. 17. The Plan agrees that meritorious benefits claims should be paid promptly, but the standard of review has no bearing on the timing of benefits payments. The whole point of the "deemed denied" provision of the former regulation and the related term in the Plan itself is to enable a claimant to seek prompt judicial review in the event that the administrator does not issue a final decision within a given period of time. That exception to the exhaustion requirement, rather than the standard of review, ensures that claimants receive their benefits in a timely fashion.

Jebian next takes issue with the Plan's argument that automatic *de novo* review for deemed denials will lead to more denials of benefits. Opp. 18; *see* Pet. 24. Jebian's skepticism notwithstanding, judges have voiced that same concern repeatedly. *See Gilbertson*, 328 F.3d at 634-35 ("Even in cases where additional medical information is clearly necessary for a proper decision, administrators would have an incentive to issue a final denial on the inadequate record in order to preserve their right to deferential review, rather than to wait for the information and risk losing defer-

ence."); Pet. App. 29a (Tashima, J., dissenting) ("the majority's decision will force plan administrators to deny ... claims within the permitted period, rather than to risk awaiting receipt of the required medical records so that a more reasoned decision, one based on a review of the full medical records, can be made").

Jebian's final argument, that the Plan grants discretion to the claims administrator only where the administrator acts within the time limits specified by the Plan (Opp. 20), merely assumes its conclusion, and it ignores the analysis of this issue presented in the petition (at 17-21). The Plan respectfully submits that the scope of administrative discretion in these circumstances warrants plenary review by the Court.

CONCLUSION

The petition for a writ of certiorari should be granted.

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No. 03-1202

IN THE

Supreme Court of the United States

HEWLETT-PACKARD COMPANY EMPLOYEE BENEFITS ORGANIZATION INCOME PROTECTION PLAN,

Petitioner,

v.

DONALD JEBIAN,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

SUPPLEMENTAL BRIEF FOR PETITIONER

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SUPPLEMENTAL BRIEF FOR PETITIONER

Pursuant to this Court's Rule 15.8, petitioner respectfully submits this supplemental brief to address the *amicus curiae* brief filed by the United States. The government argues that certiorari should be denied for three reasons, none of which has merit. The government's contention that the decision below is correct (U.S. Br. 12-16) is addressed fully in the petition (Pet. 17-21) and would be the subject of merits briefing if this Court were to grant plenary review. *See also* n.*, *infra*. The government's remaining arguments—that there is no "real" conflict among the circuits (U.S. Br. 6-12) and that the question presented is of limited and diminishing importance (*id.* at 16-20)—turn a blind eye to the confusion that continues to frustrate the lower courts, ERISA fiduciaries, and plan participants. As numerous recent cases confirm, similar facts continue to yield inconsistent and unpredictable outcomes. Indeed, after the government's *amicus* brief was filed, the Ninth Circuit rendered a decision that is clearly at odds with its decision in this matter, prompting Circuit Judge Rymer to specifically note the pending petition for a writ of certiorari in this case as a means of resolving the extant conflict. *Gatti* v. *Reliance Standard Life Ins. Co.*, — F.3d — , 2005 U.S. App. LEXIS 9895, at *19 (9th Cir. 2005) (concurring in part). Only this Court's review of this important issue of federal benefits law can resolve this chaos in the circuits and restore the "uniform administrative scheme" that ERISA was designed to establish. *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 9 (1987).

I. Recent Decisions Confirm That A Mature Conflict Among The Circuits Persists

Petitioner has previously demonstrated the three-way split among the circuits regarding the standard of review courts should apply to an ERISA plan administrator's denial of a benefits claim when that claim is "deemed" denied as a

result of passage of time. *See* Pet. 11-17; Pet. Reply 4-8. The government now attempts to gainsay that conflict, contending in essence that all of the circuits have adopted, or are likely to adopt, a "context-dependent" approach. U.S. Br. 6-12. The government is wrong.

Several appellate rulings issued after petitioner filed its reply brief confirm that the circuits remain committed to divergent approaches to this issue. For example, in *Finley* v. *Hewlett-Packard Co. Employee Benefits Organization Income Protection Plan*, 379 F.3d 1168 (10th Cir. 2004), and in a matter involving the same benefits plan as is involved in this case, the Tenth Circuit unequivocally stated: "The circuits are split on this issue." *Id.* at 1173 n.5 (describing at least three different approaches to this issue followed by the circuits, specifically noting that the Ninth Circuit's decision below conflicts with the approaches followed by the Fifth and Eighth Circuits). In April of this year, the Second Circuit likewise observed: "Our sister courts of appeal have again split on the question of whether a 'deemed denied' claim is always entitled to de novo review." *Nichols* v. *Prudential Ins. Co. of Am.*, 406 F.3d 98, 2005 U.S. App. LEXIS 6837, at *29 (2d Cir. 2005) (identifying three-way split). Thus, the courts faced with this issue continue to acknowledge the divergent approaches petitioner has identified—a divergence that warrants this Court's consideration.

Indeed, the disharmony resulting from these various approaches is underscored by the disparate results in recent cases. In *Finley*, the employee's claim for long-term disability benefits was denied by the plan's claims administrator. She filed an administrative appeal that included a new medical report. 379 F.3d at 1171. The claims administrator requested that she provide additional evidence. *Ibid.* The employee provided none, and the appeal was denied more than 120 days after it was filed. "Therefore, pursuant to both section 8(c) of the benefits document and the applicable ERISA

regulation, [the employee's] appeal was 'deemed denied.'" *Id.* at 1172. Although the Ninth Circuit held in the decision below that the late denial of an administrative appeal warranted *de novo* review, the Tenth Circuit in *Finley* reviewed the very similar denial there under an abuse of discretion standard. 379 F.3d at 1174-75. The *Finley* court reasoned that because the claims administrator's initial denial and statement of reasons could "effectively be applied" to the administrative appeal, and the delay did not "undermine [the court's] confidence in the integrity of [the administrator's] decision-making process," the administrator's decision would be reviewed for an abuse of discretion. *Ibid.* (citations omitted).

In *LaMantia* v. *Voluntary Plan Administrators, Inc.*, 401 F.3d 1114 (9th Cir. 2005), which also involved Hewlett-Packard's long-term disability plan, the claims administrator denied the employee's claim for long-term disability benefits. The employee filed an administrative appeal, and at her counsel's request the claims administrator granted an extension of time for the employee to submit medical reports in support of her appeal. *Id.* at 1117. Well over a year then passed without further communication between the employee and the claims administrator. *Ibid.* Eventually, the employee's counsel submitted further medical reports, and the claims administrator ultimately sent the claimant a letter denying the appeal on the merits. The final denial of the appeal occurred more than four years after the employee commenced her appeal. *Ibid.* The Ninth Circuit concluded that the "[m]ost significant[]" factor distinguishing *Jebian* was that in *LaMantia* the employee "was the party who sought an extension of time which caused the deadline to file documents to occur beyond the deemed-denial date." *Id.* at 1123. The court then noted the public policy consideration militating against an automatic *de novo* standard any time a deemed denial occurs, observing that "[o]therwise, claims administrators would have no incentive to allow extensions beyond the

deemed-denial period when claimants seek an extension." *Id.* at 1124. The court remanded the matter for decision under the abuse of discretion standard. *Ibid.*

LaMantia serves to illustrate the confusion this issue has engendered even within the Ninth Circuit. In the matter at hand, the very same claims administrator advised respondent that his claim would be "left open" to permit him to submit additional medical evidence in support of his claim if he so chose. It was the claims administrator's unilateral decision to give respondent more time to permit him to develop his record that caused the Ninth Circuit to rule that the *de novo* standard of review would apply to respondent's district court challenge of the decision to deny his claim—directly analogous to the decision that led the *LaMantia* court to apply the abuse of discretion standard.*

Most recently, after the government filed its *amicus curiae* brief in this case, the Ninth Circuit issued its decision in *Gatti* v. *Reliance Standard Life Insurance Co.*, — F.3d —, 2005 U.S. App. LEXIS 9895 (9th Cir. 2005). In *Gatti*, the employee administratively appealed a denial of benefits, and the administrator affirmed the denial 177 days after receiving the request for review, which was well after the occurrence of a regulatory deemed denial. *Id.* at *2-3. The administrator

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* The government, like the majority opinion below, attempts to perpetuate the myth that the claims administrator here failed to carry out its duties faithfully and effectively. U.S. Br. 15-16. VPA clearly informed respondent of what specific information was required, followed up with respondent when that information had not been received, and expressed a willingness to keep respondent's file open until it received that information. C.A. Supp. App. 69, 92; Pet. App. 35a. Judge Tashima criticized "the majority's characterization of the facts" and noted the district court's finding that the parties were engaged in "meaningful dialogue" regarding respondent's appeal. Pet. App. 29a-30a. Thus, the facts here would warrant abuse of discretion review under at least two of the three approaches the circuits have adopted. *See* Pet. 11-12, 14-17.

thereafter gave the employee a further opportunity to present new medical evidence, and the employee did so. Finally, 279 days after the appeal commenced, the administrator decided that the additional medical information did not warrant a reversal of the benefits denial. *Id.* at *3. The Ninth Circuit "conclude[d] that *Jebian* does not control the issue presented here, and h[e]ld that violations of the time limits established in 29 C.F.R. § 2560.503-1(h) [1998] are insufficient to alter the standard of review." *Id.* at *6. The court distinguished *Jebian* on the basis that the plan in *Jebian* contained "deemed denial" language, whereas the only deemed denial provision applicable in *Gatti* was the language of the regulation. *Id.* at *7. The *Gatti* court held that the proper standard of review is abuse of discretion, rejecting the employee's argument that "the 'deemed denied' language operates to cut off the administrator's discretion." *Id.* at *8. "Instead, we read the 'deemed denied' language to provide beneficiaries with a 'final decision' from which to appeal if the administrator has not made a decision within the timelines established in the regulation." *Ibid.* The court noted that "[n]othing in the history of ERISA or its regulations, nor in the precedent that binds us, indicates that the 'deemed denied' language is a temporal restriction on the administrator's discretion." *Id.* at *12-13.

Concurring in part in *Gatti*, Judge Rymer stated: "I agree with Judge Tashima's dissent in *Jebian* but am hard-pressed to say that 'deemed denials' can mean one thing if embedded in a Plan and another if established by regulation." 2005 U.S. App. LEXIS 9895, at *19 (Rymer, J., concurring in part). Judge Rymer would have deferred ruling on the standard of review issue or remanded the matter to the district court "pending the Supreme Court's decision whether to grant certiorari in *Jebian*." *Ibid.*

As these cases demonstrate, and as Judge Rymer recognized not 10 days ago, the circuits remain deeply divided re-

garding the standard of review. *See also* Pet. 11-17 (detailing three-way circuit split). The Ninth Circuit has recently added additional unique wrinkles to the law, further distancing its position from that of other circuits. *LaMantia* created a rule whereby the standard of review depends substantially on which party caused the delay. *Gatti* establishes that "deemed denied" regulatory language will be construed differently from virtually identical plan language. *LaMantia* and *Finley* are irreconcilable, because the administrator's delay in *Finley* nevertheless led to abuse of discretion review, whereas under *LaMantia* the Ninth Circuit would have applied the *de novo* standard. Moreover, the Fifth and Sixth Circuits are clearly on record as adopting a rule that deemed denials do not result in *de novo* review, and the government's attempt to sweep that prong of the circuit split under the rug by speculating that those courts might reach a different result if they were to address the question today (U.S. Br. 11-12) is unpersuasive. Thus, the circuits are plainly divided on this issue, and this Court's guidance is urgently needed.

II. The Question Presented Remains Important And Worthy Of Review

The government suggests that the Department of Labor's modification of the claims processing regulation in 2000 renders the circuit split here of diminishing importance. U.S. Br. 16-20. The government misunderstands the issue. As this Court has explained, the level of discretion conferred upon an administrative decision "is simply a matter of plan design," and the standard of review is not controlled by ERISA or its regulations. *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355, 385-86 (2002). Ultimately, the issue is a matter of construing plan language, and the question petitioner has presented (Pet. i) is not limited to the effect of the regulation, as the government mistakenly suggests. U.S. Br. I.

The Ninth Circuit's very recent *Gatti* decision correctly holds that under the 1998 version of the regulations, the oc-

currence of a regulatory deemed denial does not alter the standard of review. The result appears to be the same under the new regulation, which eliminates the concept of a deemed denial. However, as Judge Rymer's partial concurrence in *Gatti* cogently observes (2005 U.S. App. LEXIS 9895, at *19 (Rymer, J., concurring in part)), it makes no sense to hold that a regulatory deemed denial does not affect the standard of review, while construing virtually identical language in a plan—indeed, language added to the plan to track the regulatory provision—as depriving an administrator of discretion and to warrant *de novo* review.

Regardless of the impact of the new regulation, the fact remains that the courts of appeals continue to issue conflicting decisions under the former regulatory framework at a brisk pace, including several decisions within the past few months. The courts regard this issue as a matter of continuing importance. Moreover, the government's *amicus* brief fails to acknowledge the "large leeway" that ERISA grants employers to design welfare plans as they see fit. *Black & Decker Disability Plan* v. *Nord*, 538 U.S. 822, 833 (2003); *see also Lockheed Corp.* v. *Spink*, 517 U.S. 882, 887 (1996). Because neither ERISA nor the amended regulation addresses the use of "deemed denied" language in plans, employers can and will continue to use such provisions, and cases raising the question presented here will continue to arise. The inconsistent, outcome-determinative approaches that the circuits apply regarding the standard of review call out for review by this Court.

CONCLUSION

The petition for a writ of certiorari should be granted.

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No. 03-1202

In the Supreme Court of the United States

HEWLETT-PACKARD COMPANY EMPLOYEE BENEFITS ORGANIZATION INCOME PROTECTION PLAN, PETITIONER

v.

DONALD JEBIAN

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTION PRESENTED

In *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101 (1989), this Court held that the denial of employee benefits by an administrator under the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 *et seq.*, was entitled to deference when the plan conferred discretion on the administrator to determine eligibility for benefits. Under 29 C.F.R. 2560.503-1(h)(4) (2000), a claim for benefits is "deemed denied on review," thereby enabling the claimant to bring suit, if the specified fiduciary (here, the claims administrator) failed to review an initial decision to deny benefits within a certain period. The question presented is as follows:

Whether an administrator's decision to deny benefits on appeal is entitled to deference when the claim for benefits had been "deemed denied on review" under 29 C.F.R. 2560.503-1(h)(4) (2000).

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In the Supreme Court of the United States

No. 03-1202

HEWLETT-PACKARD COMPANY EMPLOYEE BENEFITS ORGANIZATION INCOME PROTECTION PLAN, PETITIONER

v.

DONALD JEBIAN

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

This brief is filed in response to the Court's invitation to the Acting Solicitor General to express the views of the United States. The position of the United States is that further review of this case is not warranted.

STATEMENT

1. The Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, regulates employee welfare and pension benefit plans, including disability plans. 29 U.S.C. 1001(a), 1002(1). ERISA requires every covered employee benefit plan to provide a two-stage process for the evaluation of employees' benefit claims. At the first stage, if the plan denies the claim, it must "provide adequate notice in writing * * *, setting forth the specific reasons for such denial." 29 U.S.C. 1133(1). At the second stage, the plan must "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by

the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. 1133(2). A claimant may file suit to recover benefits due under the terms of the plan. 29 U.S.C. 1132(a)(1)(B). Courts have uniformly held that the claimant must exhaust his administrative remedies with the plan before filing suit. See, *e.g.*, *Fallick* v. *Nationwide Mut. Ins. Co.*, 162 F.3d 410, 418 & n.4 (6th Cir. 1998) (listing cases).

Pursuant to statutory mandate, see 29 U.S.C. 1133, the Secretary of Labor has promulgated regulations governing the two-stage claims process. Under the prior version of the regulations, which governs this case, a plan was required to notify a claimant of its initial decision within a reasonable period of time, not to exceed 90 days absent special circumstances (and 180 days in any event) from the filing of the claim. 29 C.F.R. 2560.503-1(e)(1) and (3) (2000). If notice of the denial was not provided within that period, the claim was "deemed denied," and the claimant was permitted to proceed to the appeal stage. 29 C.F.R. 2560.503-1(e)(2) (2000). At that stage, the specified fiduciary was required to make a decision within 60 days, unless special circumstances required an extension of time for processing, but in that event no later than 120 days after receipt of the request for review. 29 C.F.R. 2560.503-1(h)(1)(i) (2000). If an extension of time was necessary because of special circumstances, the administrator was required to furnish written notice to the beneficiary prior to commencement of the extension. 29 C.F.R. 2560.503-1(h)(2) (2000). If the fiduciary failed to furnish its decision to the claimant within the period allowed, the claim was "deemed denied on review." 29 C.F.R. 2560.503-1(h)(4) (2000).[1]

2. Petitioner is an ERISA-covered plan with an independent claims administrator. Pet. App. 3a. The plan contained procedural requirements, including "deemed denied"

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[1] As explained below, the Secretary promulgated new regulations in 2000 that delete the "deemed denied" provision and impose new and more flexible deadlines. See pp. 16-20, *infra*.

provisions, that were consistent with the regulations then in effect. *Id.* at 136a-142a. Although the plan did not give the claims administrator discretion in making initial claims decisions, *id.* at 136a-139a, it did confer discretion on the administrator in making decisions on appeal, including "the authority to determine eligibility for benefits and to construe the terms of the Plan," *id.* at 139a.

Respondent was a participant in the plan. In February 1998, respondent applied for long-term disability benefits because of back and shoulder pain. Pet. App. 2a-4a. On August 3, 1998, the claims administrator denied the application. *Id.* at 4a. On August 18, 1998, respondent informed the claims administrator in writing of his intent to appeal, and he formally submitted his appeal (together with new medical evidence) on November 11, 1998. *Id.* at 34a-35a. On March 15, 1999, some 119 days after receiving the formal appeal, the claims administrator wrote to respondent, addressing respondent's objections to the initial decision but leaving the appeal open to consider further medical evidence. *Id.* at 5a. On June 11, 1999, the claims administrator again wrote to respondent, indicating that the appeal remained open pending the receipt of additional documentation. *Id.* at 6a. On September 29, 1999, respondent filed suit in federal district court, seeking to recover benefits under 29 U.S.C. 1132(a)(1)(B). Pet. App. 7a. On November 5, 1999, the claims administrator notified respondent that his appeal had been denied, and provided a detailed explanation for the denial. *Id.* at 7a, 36a.

3. Both parties then moved for summary judgment in the district court. Petitioner contended that the claims administrator's decision to deny benefits on review was entitled to deference under *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101 (1989), in which this Court held that an administrator's decision to deny benefits was entitled to deference when the plan conferred discretion on the administrator to determine benefit eligibility. Respondent contended that, once his

administrative appeal was "deemed denied" because the administrator had failed to issue a timely decision, the administrator was divested of any discretion in deciding the appeal, the denial was thus not entitled to deference, and the suit for benefits should be decided *de novo* by the district court. The district court agreed with petitioner on the standard of review and granted summary judgment to petitioner on the merits. Pet. App. 31a-41a, 44a-46a.

4. a. The court of appeals reversed and remanded. Pet. App. 1a-30a. The court held that, where the applicable plan and regulatory language provide that a claim is "deemed denied" on review after the expiration of a given time period, "there is no opportunity for the exercise of discretion and the denial is usually to be reviewed *de novo*." *Id.* at 7a. According to the court, "[w]hile deference may be due to a plan administrator that is engaged in a good faith attempt to comply with its deadlines when they lapse, this is not such a case." *Ibid.* The court noted that the claims administrator failed to provide written notice that additional time was required within the initial 60-day period for review; failed to provide any form of written notice until one day before the expiration of the extended 120-day period; and failed to specify, in that written notice, what additional information was required. *Id* at 8a.

In concluding that the appropriate standard of review in this case is *de novo*, the court of appeals relied on this Court's decision in *Firestone Tire*, which held that an administrator's decision was entitled to deference only when the plan conferred discretion on the administrator. Pet. App. 9a. According to the court, "[w]e are just as bound by the Plan language deeming denial in the event that time limits are exceeded as we are bound by the Plan language that grants discretion to the Plan administrator." *Ibid.* The court thus concluded that "[d]ecisions made outside the boundaries of conferred discretion are not exercises of discretion, the substance of the deci-

sions notwithstanding." *Ibid.* The court reasoned that such a rule is consistent with the general rule applicable to judicial review of federal agency decisions, *id.* at 9a-10a, and with the rule that deference is not owed to a decision to deny benefits under an ERISA plan when the decision was made by an entity other than the one authorized to do so in the plan, *id.* at 10a.

Finally, the court of appeals reiterated that, "[a]bsent unusual circumstances, an administrator engaged in a genuine, productive, ongoing dialogue that substantially complies with a plan's and the regulations' timelines should remain entitled to whatever discretion the plan documentation gives it." Pet. App. 15a. But because the claims administrator here had failed to engage in such an "ongoing, good faith exchange," the court concluded, *de novo* review was appropriate. *Ibid.* After reviewing the evidence, the court found a genuine issue of fact concerning whether respondent is disabled, and it remanded the case to the district court to decide that issue *de novo*. *Id.* at 16a-20a.[2]

b. Judge Tashima dissented. Pet. App. 21a-30a. In his view, *de novo* review was not required simply because of a procedural irregularity in the administrator's handling of a claim. *Id.* at 21a-25a. Judge Tashima also stated that, even under the majority's rule, *de novo* review was not appropriate in this case because "[t]he facts indicate * * * that [the claims administrator] was attempting to engage in a meaningful exchange of information with [respondent]." *Id.* at 29a.

DISCUSSION

The petition for a writ of certiorari should be denied. The court of appeals' decision to conduct *de novo* review of respon-

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[2] The court of appeals held that, in applying a *de novo* standard of review, the district court could consider evidence outside the administrative record. Pet. App. 19a. Petitioner does not expressly challenge that holding in the petition.

dent's benefits claim in the particular circumstances of this case was reasonable. Although there is some divergence among circuits on the question whether the decision of an administrator with discretionary authority is entitled to deference when the claim for benefits was "deemed denied on review" under the Secretary's prior regulations, the cases implicated in that circuit conflict can largely be reconciled. Equally important, since the events at issue in this case, the Secretary of Labor has promulgated new regulations that, *inter alia*, eliminate the regulatory "deemed denied" directive. Because the analysis may differ under the new regulations, this case presents a question of limited and diminishing importance. Accordingly, further review is not warranted.

A. Although The Courts of Appeals Have Taken Varied Approaches To The Standard Of Judicial Review For "Deemed Denied" Claims, There Is Not A Clear And Current Split Warranting This Court's Review.

1. This Court has twice addressed the standard of judicial review in suits for ERISA benefits under 29 U.S.C. 1132(a)(1)(B). In *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101 (1989), the Court stated the general rule that a denial of benefits under ERISA is "to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.* at 115. The Court began by noting that Section 1132(a)(1)(B) does not prescribe a particular standard of review. 489 U.S. at 109. The Court therefore determined that the appropriate standard of review should be "guided by principles of trust law," under which *de novo* review is the default rule. *Id.* at 111-112. However, the Court reasoned that a deferential standard of review is appropriate when "a trustee exercises discretionary powers." *Id.* at 111. Applying that rule in the ERISA context, the Court concluded that the denial of benefits should be

subject to deferential review when the benefit plan confers discretion on the administrator. *Id.* at 115.

More recently, in *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355 (2002), the Court held that ERISA did not preempt a state statute that required a health maintenance organization furnishing health benefits to an ERISA-covered plan to provide a medical service if a reviewing physician concluded that the service was medically necessary. *Id.* at 386-387. In so concluding, the Court briefly revisited its discussion in *Firestone Tire* of the appropriate standard of review. After reiterating the rule of *Firestone Tire*, *id.* at 384, the Court again noted that nothing in ERISA itself expressly speaks to the standard of judicial review for benefit claims, and that there is no requirement derived from ERISA that "even indirectly" compels a lenient standard of review, *id.* at 385.

Taken together, *Firestone Tire* and *Rush Prudential* establish the following principles: (1) nothing in ERISA entitles plans to deferential review in all cases, *Rush Prudential*, 536 U.S. at 385; (2) *de novo* review of benefit claims is the "general or default rule" under ordinary principles of trust law, *id.* at 385-387; and (3) deferential review is appropriate when an administrator "exercises discretionary powers," *Firestone Tire*, 489 U.S. at 111.[3]

2. Petitioner does not contend that the decision below conflicts with any decision of this Court. Instead, petitioner

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[3] In *Massachusetts Mutual Life Insurance Co.* v. *Russell*, 473 U.S. 134 (1985), the Court held that a claimant could not recover extracontractual damages from a plan fiduciary on account of the fiduciary's untimely processing of the underlying claim. *Id.* at 148. Although the Court did not address the standard of judicial review applicable in cases in which a claim was "deemed denied on review" under the version of the claims regulations then in effect, the Court did note that the regulations "enable[d] a claimant to bring a civil action to have the merits of his application determined, just as he may bring an action to challenge an outright denial of benefits." *Id.* at 144.

contends (Pet. 11-17; Reply Br. 4-8) that there is a circuit conflict warranting this Court's intervention on the appropriate standard of review in cases in which the underlying claim for benefits was "deemed denied on review" under the Secretary's prior regulations. Petitioner overstates the extent of divergence in the courts of appeals.

a. A number of circuits that have addressed the issue, including the Ninth Circuit in the decision below, have held that an administrator's decision in a "deemed denied" case may be entitled to deference depending on the extent to which the administrator complied with ERISA's procedural requirements. In a decision followed by the Ninth Circuit in this case (Pet. App. 14a-15a), the Tenth Circuit held that, "when substantial violations of ERISA deadlines result in the claim's being automatically deemed denied on review, the district court must review the denial *de novo*." *Gilbertson* v. *Allied Signal, Inc.*, 328 F.3d 625, 631 (2003). On the other hand, when there was "an ongoing, good faith exchange of information between the administrator and the claimant," "inconsequential violations of the deadlines or other procedural irregularities would not entitle the claimant to *de novo* review." *Id.* at 635. The Tenth Circuit ultimately concluded that the administrator in that case was not in substantial compliance because it had failed to participate in a "meaningful dialogue" with the claimant, and in fact had never issued a decision on appeal. *Id.* at 636.

By contrast, in a subsequent decision, the Tenth Circuit held that a claims administrator was in substantial compliance, and its decision was entitled to deference on judicial review, when the claimant had presented no relevant new evidence on appeal and the administrator had denied the appeal only 27 days late. *Finley* v. *Hewlett-Packard Co. Employee Benefits Org. Income Protection Plan*, 379 F.3d 1168, 1172, 1174 (2004). Indeed, the Ninth Circuit itself—relying both on the Tenth Circuit's decision in *Gilbertson* and on its

own decision in the instant case—has since applied a deferential standard of review in a case in which the administrator missed the regulatory deadline but had engaged in good-faith communication with the claimant. *LaMantia* v. *Voluntary Plan Adm'rs, Inc.*, 401 F.3d 1114, 1122-1124 (2005).[4]

More recently, the Second Circuit held that the *de novo* standard should be applied in a case in which the administrator did not render a decision before the "deemed denied" deadline. *Nichols* v. *Prudential Ins. Co.*, 406 F.3d 98 (2005). In so doing, the Second Circuit specifically left open the question whether deferential review would be appropriate where there was substantial compliance with the regulatory deadline, as the Ninth and Tenth Circuits had suggested, because there was no substantial compliance in that case. *Id.* at 109-110.

While not expressly adopting a "substantial compliance" standard, the Eighth Circuit has taken a similarly context-

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[4] In *LaMantia*, the Ninth Circuit also relied on the fact that it was the claimant who sought an extension to file additional documents, which caused the decision to be rendered beyond the "deemed denied" deadline. 401 F.3d at 1123-1124. The court noted that, by allowing more information to be filed after the deadline and then rendering a decision on the merits, the administrator was exercising discretion under the plan. *Id.* at 1123. If an administrator's decision were subject to *de novo* review in those circumstances, the court explained, there would be no incentive for an administrator to allow extensions for the benefit of claimants. *Id.* at 1124. Because the "deemed denied" provision of the prior regulations was for the claimant's benefit, and because the standard of review in suits for benefits under Section 1132(a)(1)(B) derives from trust principles developed in equity, the Ninth Circuit appropriately attached significance to the claimant's role in causing the delay.

Petitioner contends (Pet. 16 n.7; Reply Br. 6) that the Ninth Circuit in the instant case "paid lip service to the Tenth Circuit's 'substantial compliance' approach" and "in reality" applied a uniform *de novo* standard of review. That assertion is incorrect and belied by the Ninth Circuit's subsequent decision in *LaMantia*. The question whether the Ninth Circuit correctly applied its context-dependent rule in the circumstances of this case does not warrant this Court's review.

dependent approach. In *McGarrah* v. *Hartford Life Insurance Co.*, 234 F.3d 1026 (8th Cir. 2000), the court held that the failure of an administrator to respond to a claimant's request for review was insufficient, by itself, to subject the administrator's initial decision to *de novo* review. *Id.* at 1031. Instead, the court reasoned, an administrator's decision would be subject to *de novo* review only if any procedural irregularity "raise[d] * * * 'serious doubts as to whether the result reached was the product of an arbitrary decision or the plan administrator's whim.'" *Ibid.* (quoting *Buttram* v. *Central States, S.E. & S.W. Areas Health & Welfare Fund*, 76 F.3d 896, 900 (8th Cir. 1996)). The court concluded that the claimant had failed to meet that standard because the administrator had made a thorough investigation and adequately explained the reasons for the termination of disability benefits in its initial decision, and because the claimant had presented no new medical evidence on appeal. *Ibid.* Applying the same standard, the Eighth Circuit subsequently reached the opposite result in a case in which the claimant had presented substantial new evidence on appeal, including reports from five doctors. *Seman* v. *FMC Corp. Retirement Plan for Hourly Employees*, 334 F.3d 728, 733 (8th Cir. 2003).[5]

Finally, the Third Circuit applied a *de novo* standard of review in *Gritzer* v. *CBS, Inc.*, 275 F.3d 291 (2002), where the plan administrator had not issued even an initial decision by the time the claimants had filed suit and did not do so until nearly five months later. See *id.* at 294-295. In those circumstances, the Third Circuit agreed with the claimants that

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[5] To the extent that the Eighth and Tenth Circuits have suggested that an administrator's *initial* decision for review may be entitled to deference when the claimant failed to provide new evidence or raise new issues at the appeal stage and the claim was deemed denied on appeal, that theory would not be available here, because petitioner's plan conferred discretion on the claims administrator only at the appeal stage and not at the initial stage. Compare Pet. App. 136a-139a (initial stage) with Pet. App. 139a-142a (appeal stage).

"there simply is no analysis or 'reasoning' to which the Court may defer under the arbitrary and capricious standard." *Id.* at 296 (internal quotation marks omitted). Applying the trust principles on which this Court relied in *Firestone Tire*, the Third Circuit reasoned that, "[w]here a trustee fails to act or to exercise his or her discretion, de novo review is appropriate because the trustee has forfeited the privilege to apply his or her discretion; it is the trustee's analysis, not his or her right to use discretion or a mere arbitrary denial, to which a court should defer." *Ibid.* The result reached by the Third Circuit in *Gritzer* is fully consistent with the decisions of the Ninth Circuit and the other circuits discussed above, and its decision does not appear to foreclose a deferential standard of review where there was substantial compliance with the regulatory deadlines.

b. Two circuits, the Fifth and Sixth, have applied a deferential standard of review, seemingly without qualification, to an administrator's initial decision where the administrator failed to issue a decision on appeal. The Sixth Circuit, however, addressed the issue 17 years ago, even before this Court's decision in *Firestone Tire*, in which the Court made clear that *de novo* review, not deferential review, is the default rule. *Daniel* v. *Eaton Corp.*, 839 F.2d 263, 267 (6th Cir.), cert. denied, 488 U.S. 826 (1988). Since *Firestone Tire*, the Sixth Circuit has recognized that "there is undeniable logic in the view that a plan administrator should forfeit deferential review by failing to exercise its discretion in a timely manner," but ultimately found it unnecessary to resolve that question in the case before it. *University Hospitals* v. *Emerson Elec. Co.*, 202 F.3d 839, 846 n.3 (6th Cir. 2000). As the court of appeals in this case observed (Pet. App. 13a), the issue thus appears to be open in the Sixth Circuit. At the very least, to the extent the Sixth Circuit's decision in *Daniel* retains force, the Sixth Circuit may well reconsider *Daniel* if confronted with the issue in the future, in light of this Court's intervening

decision in *Firestone Tire* and its own subsequent pronouncement in *University Hospitals*.

The Fifth Circuit, in a 1993 decision, held that a deferential standard of review was applicable to an administrator's factual determinations in a "deemed denied" case, stating that "the standard of review is no different whether the claim is actually denied or is deemed denied." *Southern Farm Bureau Life Ins. Co.* v. *Moore*, 993 F.2d 98, 101 (1993). As another court of appeals has noted, however, the Fifth Circuit "provided no explanation or authority for this statement." *Gilbertson*, 328 F.3d at 633. Because the Fifth Circuit's analysis in *Southern Farm Bureau* was so cursory, and because its decision in that case preceded all of the decisions from other circuits that have since provided for *de novo* review in appropriate circumstances, the Fifth Circuit may well revisit the issue, and elaborate on its analysis, if presented with the issue in another case. Indeed, the Fifth Circuit specifically noted in *Southern Farm Bureau* that the claimant in that case had presented no authority for *de novo* review, 993 F.2d at 101 n.6—a state of affairs that has now greatly changed.

c. In short, there is no clear and current conflict among the circuits warranting this Court's review on the standard-of-review issue presented here. To the contrary, in recent cases considering the issue, there is an emerging consensus that deferential review is appropriate under the Secretary's prior regulations where the administrator substantially complied with the applicable deadlines, but that *de novo* review is appropriate where it did not.

B. The Decision Below Is Correct

Consistent with the prevailing view in the cases just discussed, the court of appeals reasonably determined that *de*

novo review was appropriate in the particular circumstances of this case.[6]

1. Principles of trust law support the rule allowing *de novo* review in appropriate "deemed denied" cases. When ERISA itself and the Secretary's implementing regulations are silent, this Court has looked to trust-law principles in order to "develop a 'federal common law of rights and obligations under ERISA-regulated plans.'" *Firestone Tire*, 489 U.S. at 110 (quoting *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 56 (1987)). Applying those principles in *Firestone Tire*, this Court recognized a default rule that an administrator's decision to deny benefits under ERISA was reviewed *de novo*, but that more deferential review was warranted when the administrator was "exercis[ing] discretionary powers." *Id.* at 111.

When an ERISA administrator having discretion under the plan fails to issue a decision on review at all, or fails to comply substantially with the mandatory deadlines and the claim is therefore "deemed denied," the administrator has failed to act within the scope of the discretion conferred by the plan. That is so because the administrator's discretion is necessarily limited by the governing regulations as well as by the terms of the plan itself, which in this case incorporated the regulations' deadlines and "deemed denied" language. Pet. App. 140a-141a; 29 U.S.C. 1104(a)(1)(D), 1133; cf. Restatement (Second) of Trusts § 187 cmt. a (1959) ("The exercise of a power is discretionary except to the extent to which

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[6] Contrary to the assertions of both parties (Pet. 21 n.8; Br. in Opp. 9-11), the Department of Labor has not previously taken a position on the applicable standard of review in cases in which the claim for benefits was "deemed denied on review" under the prior regulations. The parties' assertions are based only on explanatory materials issued in connection with the new regulations, see Br. in Opp. 10, and on interpretive guidance on the Department's website concerning the discrete question of when exhaustion of plan remedies is required under the new regulations, see Pet. 21 n.8.

its exercise is required by the terms of the trust or by the principles of law applicable to the duties of trustees.").

It is, in fact, well established under the law of trusts that, "even where a trustee has discretion whether or not to make any payments to a particular beneficiary, the court will interpose if the trustee, arbitrarily or without knowledge of or inquiry into relevant circumstances, fails to exercise that discretion." Restatement (Third) of Trusts § 50 cmt. b (2003); accord Restatement (Second) of Trusts § 187 cmt. h (1959); 3 Austin W. Scott & William F. Fratcher, *The Law of Trusts* § 187.3, at 40-44 (4th ed. 1988) (Scott & Fratcher). Under those circumstances, a court is free to take new evidence, make its own judgment about the benefits due, and order payment by the trustee or remand the matter to the trustee with instructions, as it sees fit. Restatement (Third), *supra*, § 50 cmt. b; 3 Scott & Fratcher § 187.1, at 27-32; *Colton* v. *Colton*, 127 U.S. 300, 322 (1898). Applying those principles in the ERISA context, if an administrator failed to comply substantially with mandatory deadlines under governing regulations and plan terms that deem a claim to be denied in the event of such a failure, the administrator has not acted within the scope of its discretion, and the default rule of *de novo* review is appropriate.

b. Application of the default rule in these circumstances creates an incentive for plan administrators to comply with the processing deadlines under the Secretary's regulations. Although the Secretary's earlier regulations governing review of claims for disability benefits did not purport to specify a standard of review for claims "deemed denied on review," they did make clear that the deadlines for the processing of benefit claims were mandatory. Thus, the regulations specified that the initial notice of denial "*shall* be furnished to the claimant within a reasonable period of time," not to exceed 180 days from the filing of the claim. 29 C.F.R. 2560.503-1(e)(1) and (3) (2000) (emphasis added). If notice of the denial

was not provided within that period, the claim "*shall* be deemed denied," and the claimant "*shall* be permitted to proceed" to the appeal stage. 29 C.F.R. 2560.503-1(e)(2) (2000) (emphases added). At the appeal stage, in turn, the regulations provided that a decision "*shall* be made promptly," and in no event more than 120 days from the filing of the request for review. 29 C.F.R. 2560.503-1(h)(1)(i) (2000) (emphasis added). Finally, if the fiduciary failed to furnish its decision to the claimant within that period, the claim "*shall* be deemed denied on review." 29 C.F.R. 2560.503-1(h)(4) (2000) (emphasis added).

In promulgating those provisions immediately after ERISA's enactment, the Secretary of Labor recognized that they were vital to the ERISA claims-resolution process. In fact, although those regulations as originally proposed contained time limits only for decisions on review, see 39 Fed. Reg. 42,243 (1974), the final regulations contained time limits for initial decisions as well, in response to comments that such time limits were necessary to "induce plans to process the initial claim promptly" and to "eliminate unreasonable delays in responding to claims," 42 Fed. Reg. 27,427 (1977). That interest in inducing plans to process claims promptly supports *de novo* review in appropriate cases in which the plan administrator failed substantially to comply with the mandatory deadlines.

c. In this case, the court of appeals reasonably concluded that, "while deference may be due to a plan administrator that is engaged in a good faith attempt to comply with its deadlines when they lapse, this is not such a case." Pet. App. 7a. After petitioner denied respondent's claim at the initial stage, respondent appealed and submitted new medical evidence to support his claim. *Id.* at 34a-35a. Petitioner failed to provide the required written notice that additional time was required within the initial 60-day period for review; failed to provide any form of written notice until one day before the expiration

of the extended 120-day period; and failed to specify, in that written notice, what additional information was required. Moreover, petitioner did not issue a decision until a year after the appeal was filed, ten months after it was "deemed denied" under the relevant regulation (and the express terms of the plan), and more than a month after respondent filed suit in federal district court. *Id.* at 5a-6a, 141a-142a. In those circumstances, *de novo* review was appropriate.

C. The Question Presented Is Of Limited And Diminishing Importance In Light Of Regulatory Changes

Finally, even if there were a sufficient circuit conflict on the appropriate standard of review in cases in which the underlying claim for benefits was "deemed denied on review" under the former regulations, and even if the decision below were erroneous in applying a *de novo* standard, further review would not be warranted because the Secretary of Labor has promulgated new regulations that abolish the regulatory concept of a deemed denial and may otherwise affect the standard-of-review issue.

1. In 2000, the Secretary replaced the former regulations governing claims procedures applicable here with comprehensive new regulations applicable to all claims filed on or after January 1, 2002. 29 C.F.R. 2560.503-1.[7] The new regulations differ in several material respects from those at issue in this case. Perhaps most important, the new regulations no longer provide that a claim will be "deemed denied on review" if the decision on review is not made within a specified period, 29 C.F.R. 2560.503-1(h)(4) (2000), and thus eliminate the "deemed denied" directive on which the Ninth Circuit and

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[7] For health-benefit claims, the effective date of the new regulation is no later than January 1, 2003. 29 C.F.R. 2560.503-1(o).

other courts specifically relied in declining to afford deference to an administrator's decision.[8]

Instead, the new regulations dispense with the exhaustion requirement and allow a claimant to proceed directly to federal court in the event of a broader range of procedural violations, including violations of newly adopted requirements contained elsewhere in the regulations. 29 C.F.R. 2560.503-1(*l*). Under the relevant provision, when a plan has failed to "establish or follow claims procedures consistent with the requirements of [the regulations]," a claimant is "deemed to have exhausted the administrative remedies available under the plan," and may file suit "on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim." *Ibid.* That provision allows such a claimant to proceed directly to court without waiting for a denial of his claim, whether "deemed" or actual. If a claimant invokes that provision and the court agrees that the plan has failed to provide a reasonable claims procedure, the court might then conclude that the default rule of *de novo* consideration is triggered as a corollary. The appropriate manner of review in various scenarios that could arise under that provision should be determined in concrete cases as they are presented in the future.

Beyond the elimination of the "deemed denied" provision, the new regulations contain other features that may affect the appropriate standard of review. First, the regulations, while modestly shortening the time for deciding disability claims, 29

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[8] Petitioner contends (Reply Br. 3) that, even though the "deemed denied" provision has been deleted from the new regulations, "the question presented remains live" because some plans may retain the "deemed denied" language as a matter of plan design. In the absence of a "deemed denied" provision in governing regulations, however, the interpretation of language in a plan deeming a claim to be denied if plan deadlines are not met, and the consequences for failing to meet those deadlines, may present different considerations than in a case controlled by the former regulations.

C.F.R. 2560.503-1(f)(3) and (i)(3), contain new and more flexible tolling provisions that enable an administrator to extend the governing time limits in cases in which the administrator requires additional information from the claimant, 29 C.F.R. 2560.503-1(f)(4) and (i)(4). Those provisions were specifically intended to "provide plans with the flexibility necessary to handle all claims appropriately, whether such claims are easy or difficult, complete when filed or needing more information." 65 Fed. Reg. 70,250 (2000). The availability of those tolling provisions addresses petitioner's concern (Pet. 22-24) that a rule under which noncompliance with rigid deadlines automatically triggers *de novo* review would penalize the plan if its administrator needed (or if the claimant wanted to submit) additional information. See, *e.g.*, Pet. App. 29a (Tashima, J., dissenting); *Gilbertson*, 328 F.3d at 634-635.[9]

Second, the new regulations provide more detailed procedural requirements for an administrator's review of an initial denial of a disability claim. The regulations specify that plan decisions on review (1) may not "afford deference to the initial adverse benefit determination," 29 C.F.R. 2560.503-1(h)(3)(ii) and (h)(4); (2) must be made by a fiduciary who is "neither the individual who made the adverse benefit determination [initially], nor the subordinate of such individual," 29 C.F.R. 2560.503-1(h)(3)(ii) and (h)(4); and (3) must, in a case requiring a medical judgment, include consultation with a health care professional who has "appropriate training and experience in the field of medicine involved in the medical judgment" and who was not consulted in connection with the initial decision, 29 C.F.R. 2560.503-1(h)(3)(iii), (h)(3)(v), and (h)(4).

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[9] The increased flexibility built into the regulations may also cause courts to refine the extent to which a rule of substantial compliance designed to accommodate situations involving "an ongoing, good faith exchange of information between the administrator and the claimant," *Gilbertson*, 328 F.3d at 631, is necessary to ameliorate the consequences of an absolute rule of *de novo* review in the face of noncompliance with the regulatory deadlines.

Those provisions were designed to increase the independence and integrity of the appeal process. 65 Fed. Reg. at 70,252-70,253. Those new requirements attach enhanced significance to appeals, and may affect the propriety of judicial deference to a plan's *initial* decision on the theory that the claimant was not prejudiced by the absence of a full and fair review on appeal. See, *e.g.*, *Finley*, 379 F.3d at 1175; *McGarrah*, 234 F.3d at 1031.[10]

2. Because the analysis under the new regulations may well differ from the analysis under the regulations applicable to this case, a decision in this case would affect only the shrinking number of extant claims filed before the effective date of the new regulations—January 1, 2002, or, for health-benefit claims, January 1, 2003. According to Department of Labor estimates published in conjunction with the new regulations, approximately 1.4 million disability claims were filed annually as of 2000. 65 Fed. Reg. at 70,263. Only approximately 25,000 of those claims were denied (much less "deemed denied") on review, and the great majority of those claimants presumably did not seek judicial review. *Ibid.*[11] Moreover, although ERISA specifies no uniform limitations period for judicial review of benefit claims under 29 U.S.C. 1132(a)(1)(B), judicial review with respect to disability claims filed before

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[10] No court of appeals, including the Fifth or Sixth Circuit (see pp. 11-12, *supra*), has yet addressed the appropriate standard of review in cases arising under the new regulations, although at least one court of appeals has specifically reserved the question. See *Finley*, 379 F.3d at 1175 n.6. Because this case arises under the prior regulations, it would not be an appropriate vehicle to consider that question.

[11] Petitioner errs in suggesting (Pet. 10, 23) that the Department of Labor has estimated that 14 million decisions annually are not made within the prescribed time limits. The figure petitioner cites refers not to disability claims, but instead only to health-benefit claims, and specifically to the number of health-benefit claims whose adjudication would have had to be accelerated to comply with the time limits in the new regulations. 65 Fed. Reg. at 70,257.

January 1, 2002, is as a practical matter likely to be substantially complete in the near future. The question of the appropriate standard of judicial review of benefit claims that were "deemed denied" under the prior regulations therefore is of limited and diminishing importance. For that reason, as well as the reasons given in Points A and B above, this case does not warrant the Court's review.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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